PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	49 LOK MEDICAKE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	·	495420	B. WING	r	C
NAME OF E	PROVIDER OR SUPPLIER	100120		STREET ADDRESS, CITY, STATE, ZIP CODI	06/09/2016
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ALBEMA	RLE HEALTH AND R	EHABILITATION CENTER		1540 FOUNDERS PLACE	
				CHARLOTTESVILLE, VA 22902	
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F 000	INITIAL COMMENT	-S	F (
	standard survey wa 6/9/16. Four compl the survey. Signific	Medicare/Medicaid abbreviated is conducted 6/7/16 through laints were investigated during ant corrections are required 42 CFR Part 483 Federal quirements.		Albemarle Complaint survending: 6/9/2016 The statements included a admission and do not conagreement with the allege deficiencies herein. The	are not an stitute d
F 157 SS=G	The census in this 120 certified bed facility was 69 at the time of the survey. The survey sample consisted of three current resident reviews (Residents 4 through 6) and three closed record reviews (Residents 1 through 3). 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment			correction is completed in compliance of state and for regulations as outlined. The in compliance with all federate regulations the center taken or will take the action forth in the following plan	the ederal o remain eral and er has ons set
				correction. The following correction constitutes the allegation of compliance. alleged deficiencies cited been or will be completed dates indicated.	plan of center's All have
				F157 D How the corrective action accomplished for the reaffected.	
	existing form of treat consequences, or to treatment); or a dec	need to discontinue an atment due to adverse commence a new form of cision to transfer or discharge e facility as specified in		Patient #2 no longer reside Albernarle Health and Rehabilitation Center.	es at
	• . ,	so promptly notify the resident		RECE	IVED
	and, if known, the re	esident's legal representative member when there is a		שען. 0	1 2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

change in room or roommate assignment as

JX6) OATE

Any dericiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Floministrator

6/28/14

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	 -		(OMB NO	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		ATE SURVEY EMPLETED
		495420	B, WING	}		06	C 6/ 09/20 16
NAME OF I	PROVIDER OR SUPPLIER		i		TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	70372010
41 0544	51511541741415			1	540 FOUNDERS PLACE		
ALBEMA	MRLE HEALIH AND R	EHABILITATION CENTER		C	CHARLOTTESVILLE, VA 22902		
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F 157	resident rights under regulations as spec this section.	ge 1 5(e)(2); or a change in er Federal or State law or ified in paragraph (b)(1) of cord and periodically update	F	157	How corrective action will be accomplished for those residents with the potential t affected by the same practice. Current 24 hour report will be reviewed since 6/9/2016 to ide	o b e e.	
	the address and ph legal representative	one number of the resident's or interested family member.			patients with a change in cond and to ensure the physician wa notified. Physician will be notif at that time of any identified ch	tion is ied ange	
	by: Based on staff inte clinical record revie the facility staff faile	IT is not met as evidenced rview, document review, w and complaint investigation, d to promptly notify the ge in condition for one of 6			in condition lacking documenta of physician notification. Measures in place to ensure practices will not occur.	tion	
	residents in the sun #2 was assessed w increased confusion the physician that the output when cathete physician was not in refused meals and antidiabetic medica	vey sample. When Resident ith altered mental status and in, facility staff failed to notify the resident had no urine erized for a urine sample. The informed the resident had continued to receive oral tions. The resident was sent			Staff Development Coordinator/designee will in-s charge nurses on policy and procedure for Significant Cha Condition and Documentation Summary to include assessin reporting to the physician sign symptoms of change in condi	nge of g and ns and	
	severe hypoglycem renal failure. The re hospital intensive ca	oom and diagnosed with ia (low blood sugar) and acute esident was admitted to the are unit and later died due to and lactic acidosis that failed to			How the facility plans to mo and ensure correction is achieved and sustained.		
	respond to treatment Hypoglycemia is a collision blood sugar (glucos associated with the signs and symptom recognized and treat untreated hypoglycemia is a collision of the signs and symptom recognized and treatment of the signs are significant.				Director of Nursing/designee of review 24 hour report five time week for four weeks to identify patient change in condition are ensure prompt notification of the physician. Any deficient practice will rest re-education or disciplinary as as indicated.	es a / id to he ult in	

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treatment of hypoglycemia involves quick steps to

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 2 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
		495420	B. WING	i		C 06/09/2016
	PROVIDER OR SUPPLIER RLE HEALTH AND RI	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 229		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPI	BE COMPLETION
	range - about 70 to [mg/dL]either with medications. " (4) The findings include Resident #2 was ad 4/12/16 and dischar on 5/5/16. Diagnos status post hernia re type 2 diabetes, hyphypertension, hypoxhistory of venous thidisorder, atheroscle valve stenosis and a data set (MDS) date #2 with moderately if Resident #2's close on 6/8/16. The recoorder dated 4/12/16 medication Metform administered 3 time type 2 diabetes. The physician's order dated antidiabetic medicinadministered daily for The resident's medic (MARs) documented administered as ord 9:00 a.m. on 5/5/16. Nursing notes documented documented documented documented administered as ord 9:00 a.m. on 5/5/16.	ar level back into a normal 110 milligrams per deciliter in high-sugar foods or high-sugar foods or in high-sugar	F 1	Director of Nu findings to the quarterly for tr	QA comn	nittee
		in the resident's condition				:

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5/5/16 at 12:52 a.m. -"Pt [patient] alert, confused. Insisting that she be able to put her feet on floor

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 3 of 56

DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			0	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 -	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
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(X4) 10 PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EIX (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROP FICIENCY)	BE COMPLETION
F 157	for dinner. Fluid int urinary frequency, r [bathroom]. Insiste produced no urine 5/5/16 at 4:32 a.m. some altered menta and is responding to especially when ressigns] 97.9, 100, 20 rate, respiration rate saturation 93% on rordered UA [urinalysensitivity] catheterithis time, no s/s [signoted" 5/5/16 at 6:11 a.m. administered for paragitation" 5/5/16 at 9:46 a.m. mental status, increextremities, pain, ar communication, abrupper extremities, a	If in wheelchairAppetite poor take fairC/O [complained of] refused to go into bathroomed on using bedpan, butCall to MD [physician]" - "resident is in bed noted with al status, she still verbalizes to questions appropriately sponding to family, v/s [vital D, 110/75 [temperature, pulse e, blood pressure] and oxygen room air. MD contacted and visis], C&S [culture and cized x 1 without any result, at gns/symptoms] of pain	F 1	157		
	pressure, oxygen sa temperature, respira [hospital] per family The resident's food the resident on mos from 50% to 100 %	, 95%, 89, 95.4, 20 [blood aturation, pulse rate, ation rate]Transfer to request." intake records documented st days since admission ate of meals until the evening of ords documented the resident				

refused dinner on 5/4/16 and refused breakfast on 5/5/16. The resident continued to receive the

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					NO. 0938-0391
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F 157	9:00 p.m., Glimepir the Metformin again was no notification the resident's lack of the resident's lack of the resident's lack of the resident a.m. documented altered mental statupain that started on form listed the resident at 920 and tempalso documented the rate at 95% on room recent blood glucos assessment listed to change in cognition edema and a decreate the form listed the resident's change in a.m. The form macono urine when cathesince lunch on 5/4/10.	ations Metformin on 5/4/16 at ide on 5/5/16 at 8:00 a.m. and n on 5/5/16 at 9:00 a.m. There to the physician concerning of food intake. On form dated 5/5/16 at 10:04 Resident #2 was assessed with us, edema and uncontrolled the morning of 5/5/16. The dent's vital signs as: blood, pulse rate of 89, respiration perature of 95.4. The form the resident's oxygen saturation mair. The space for the most see level was blank. The he resident had an abrupt with increased confusion, eased level of consciousness, physician was notified of the in condition on 5/5/16 at 8:15 de no mention the resident had eterized or had not eaten 16.	F 1	57			
	sugar level in respo condition. Further r record documented resident's blood sug A lab test performed physician on 5/3/16, blood sugar level wa mg/dL (milligrams/d listed as 70 to 120, orders to check or r sugar upon admissi	ssment of the resident's blood onse to the change in review of Resident #2's clinical no routine monitoring of the gar levels since her admission. If on a 4/26/16, signed by the documented the resident's as low with a reading of 64 deciliter) with a normal range. There were no physician monitor the resident's blood ion, in response to the lab her condition changed on					

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5/5/16.

Event IO: XD61t1

Facility ID: VA0417

If continuation sheet Page 5 of 56

PRINTED: 06/21/2016

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			}	1540	FOUNDERS PLACE			
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F 157	Continued From pa	ge 5	F1	57				
	included no problen regarding diabetes, mention the resider no interventions reg effects from her dai medications.	•						
	the emergency room was diagnosed with Emergency room not the resident was un hospital. Notes doo of AMS [altered mer [emergency medica [patient's] family che and found her with a They [EMS] note a land notes that she holiagnoses listed on assessment include kidney injury, altered disarray most likely lactic acidosis, urina	imented the resident arrived at n on 5/5/15 at 10:45 a.m. and severe hypoglycemia. Dies dated 5/5/16 documented responsive upon arrival to the numented, "chief complaint intal status]Per EMS I services]they state that pt's ecked on pt about 3 hours ago an altered mental status. Dlood sugar of 14 en route has received glucagon" the initial emergency room at severe hypoglycemia, acuted mental status, metabolic due to acute renal failure, ary tract infection, suspected						
	diabetes and chronic emergency record of resident's blood gluc undetectable upon a and physical dated ("Fingerstick glucose eating well for a few	ronary artery disease, type 2 c systolic heart failure. The lated 5/5/16 listed the cose (sugar) level was arrival. The hospital history 5/5/16 documented, a 14 per EMS. Patient not days prior to admission. hypoglycemia is decreased						

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po [oral] intake combined with oral hypoglycemic medications (glimepiride, metformin)." The history and physical dated 5/5/16 defined metabolic disarray as abnormal lab results that

Evenl ID: XO6111

Facility ID: VA0417

If continuation sheet Page 6 of 56

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PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0		D. 0938-0391
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		495420	B. WING				06	C 6/ 09/201 6
NAME OF	PROVIOER OR SUPPLIER			5	STREET AOORESS, CITY, STATE,	ZIP COOE		
ALBEMA	ARLE HEALTH AND R	EHABILITATION CENTER		1	1540 FOUNDERS PLACE			
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F 157	Continued From pa	ge 6	F 1	157	,	-	· ·	
	level of 6.2, high ph setting of AKI [acute acidosis. Most likel failure" (sic)	m level of 125, high potassium tosphorus level of 6.6 "all in a e kidney injury] and lactic ly etiology is acute renal						
	died on 5/7/16 after treatments. The ho dated 5/7/16 docum history of coronary a heart failure, type 2	dmitted to the hospital and she failed to respond to spital discharge summary nented the resident had a artery disease, chronic systolic diabetes and hypertension e emergency room on 5/5/16						
	with altered mental the resident was in surgical repair for a documented, "A fe #2] began to have a morning of admission	status. The summary stated the nursing facility following hernia. The summary ew days ago, she [Resident a decreased appetite. On the on, patient states that she						
	normally happens a came to visit at 8:15 lying in bed moaning EMS was called and	aide leaving her room, which round 7 am. Her daughter am and found her mother g but otherwise unresponsive. If she was taken into the ambulance, she was found to						
	have a glucose of 1- and taken to the ED where repeated fing	4. She was given glucagon [emergency department], perstick was too low to s in the ED were significant						
	for AKI [acute kidne disarray as well as li discharge summary resident was admitte	y injury] and metabolic actic acidosis" The dated 5/7/16 documented the ed to the medical intensive						,
		ent and stated, "During her her lactic acidosis failed to						!

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respond and she developed oliguric renal failure

interventions she failed to improve...dialysis was deferred and on 5/6 [2016] at which time

despite volume resuscitation...Despite

Event IO: XO6111

Facility IO: VA0417

If continuation sheet Page 7 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495420	B. WING			C 06/09/2016
-	PROVIDER OR SUPPLIER ARLE HEALTH AND RI	EHABILITATION CENTER		154	REET ADDRESS, CITY, STATE, ZIP CODE 0 FOUNDERS PLACE ARLOTTESVILLE, VA 22902	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 157	measures. Cause of failure and refractor. The nurse caring for morning hours on 5 available for intervied director of nursing (Resident #2's chang DON stated there we monitor or check Reduring her stay or of 4/26/16. The DON required a physician was called the physician was murine output or lack. On 6/8/16 at 9:40 at that cared for Resident the resident's blood in condition. The N been on oral diabetic medicines of the NP stated she of physician about whe have been ordered, diabetic medicines of should have continue eating, the NP state held the diabetic menot eating. The NP aware the resident we stated, "The nurses"	ransitioned to comfort care of death is acute oliguric renal y lactic acidosis." r Resident #2 during the early /5/16 was on leave and not ew. On 6/8/16 at 9:10 a.m. the DON) was interviewed about ge in condition on 5/5/16. The vere no physician orders to esident #2's blood sugar levels in 5/5/16 other than the lab on stated blood sugar checks it's order. The DON stated the d but there was no indication hade aware of the lack of of food intake. Im. the nurse practitioner (NP) ent #2 was interviewed about sugar monitoring and change P stated Resident #2 had could not speak for the en blood sugar checks should When asked if the oral (Metformin, Glimepiride) led when the resident was not d she probably would have edicines if she knew she was stated she was not made was refusing meals. The NP have to let us know."	F 1	57		
	consultant (RN #2)	m. the registered nurse was interviewed about any esident's blood sugar level or				

notification concerning the lack of urine output and meal refusals. RN #2 stated on the evening

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(OMB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER DR SUPPLIER ARLE HEALTH AND RI	EHABILITATION CENTER		15	REET ADDRESS, CITY, STATE, ZIP CODE 40 FOUNDERS PLACE HARLOTTESVILLE, VA 22902	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTII (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
F 157	RN #2 stated the phrurses were pushin physician ordered a catheterized the resary urine. RN #2 strecord indicating the concerning the lack presented a copy of dated 5/5/16. RN # physician was called there were no order resident's blood sugabout the lack of uri RN #2 stated, "If the physician they didn' On 6/8/16 at 3:15 p. was interviewed about and lack of blood sureviewing the clinica" would have expect stated the resident if failure and "massive her decline was relaphysician stated the failure caused liver of treatments to correct difficult. When asked mental status and dondition on 5/5/16, I would have expect [blood sugar level]." retrospect we should [Resident #2's] blood	ent started with poor appetite. hysician was called and the ang fluids. RN #2 stated the aurinalysis and the nurse sident but was unable to get tated she found nothing in the enurse called the physician of urine output. RN #2 of the change of condition form 42 stated the form listed the don 5/5/16 at 8:15 a.m. but rs given to check the gar. Concerning notification ine output and meal refusal, ey [nurses] notified the	F	157		

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catheterized and had no urine output at 4:32 a.m. on 5/5/16, the physician stated he did not recall

Event ID:XD6111

Facility ID: VA0417

If continuation sheet Page 9 of 56

PRINTED: 06/21/2016

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD STATE OF THE PLAN OF	(X3) DATI	E SURVEY PLETED	
		495420	B. WING			li .	C 09/2016
	PROVIDER OR SUPPLIER					•	
ALBEMA	ARLE HEALTH AND R	EHABILITATION CENTER		CH	ARLOTTESVILLE, VA 22902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 157	any notification abore Concerning notification autout, the physicial thought a change in call." The physician discharge summand diagnosis of "refrace physician stated refiblood sugar that we and this was most I severe heart failure. The physician stated would not have chat treatment of the low failure but stated as blood sugar assess became acutely ill. resident's blood sugar assess became acutely ill. resident's blood sugar checked especially failure, the physician explanation of why levels were not more on 6/8/16 at 4:10 p about the expected no urine was obtain DON stated nurses physician about not at 9:10 a.m. the DOS standing orders reg DON stated the fact diabetics. The DOS management were each resident.	but lack of urine output. Ition about the lack of urine In stated, "I would have In condition would create a In was shown the hospital If and asked to define the Itory hypoglycemia." The If actory hypoglycemia was low If and subsequent organ failure. If and subsequent organ failure. If the resident's putcome Inged even with earlier If all the resident when the resident If when asked why the If and subsequent organ failure. If the resident's putcome If the resident's putcome If the resident's putcome If the resident of the resident If the resident when the resident If the resident was not routinely If the reside	F	57			

FORM CMS-2567(02-99) Previous Versions Obsolete

as "a metabolic disorder characterized by hyperglycemia and results from defective insulin

Event ID:XD6111

Facility ID: VA0417

RECENTURATIONS HERE Page 10 of 56

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>MB NC</u>	<u>). 0938-0391</u>
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(X4) IQ PREFIX TAG	(EACH OFFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	Q BE	(X5) COMPLETION OATE
F 157	Continued From pa	ige 10	F ·	157			
	production, secretic this reference state known as non-insul mellitus or adult-on by a combination or insulin deficiency' page 945, "Accurat blood glucose assis daily management glucose monitoring of medicationand episodes of hypogly determine approprion pages 962 and scare for diabetes, "clevels to detect hyphypoglycemia prom The Lippincott Manedition on page 795 (AKI) as "a clinical sudden decline in redisturbances in fluid acid-base homeost regulation, erythrop production], and mi frequently associate [blood, urea, nitroge (less than 500 mL [hyperkalemia [eleva sodium and fluid resultation acidosis resultation acidos acido	on, or utilization." Page 942 of is type 2 diabetes is "formally lin-dependent diabetes set diabetes mellituscaused finsulin resistance and relative." This reference stated on e determination of capillary sts patients in the control and of diabetes mellitus. Blood helps evaluate effectiveness assists in the evaluation of ycemia and hyperglycemia to ate treatment." This reference 963 includes in standards of Closely monitor blood glucose oglycemiaTreat aptly" (1) ual of Nursing Practice 10th of defines acute kidney injury syndrome in which there is a senal function. This results in d and electrolyte balance, asis, blood pressure oiesis [red blood cell neral metabolism. It is ed with an increase in BUN en] and creatinine, oliguria milliliters] urine/24 hours), ated sodium level], and					
	have enough oxyge	en. Significant drops in blood ure, cardiac arrest and an					

(2)

overwhelming infection can cause lactic acidosis.

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CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB N	IO. 0938-0391
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUI A. BUILO		E CONSTRUCTION	(X3) C	OATE SURVEY OMPLETEO
		495420	B. WING	;			C 06/09/2016
	PROVIDER OR SUPPLIER ARLE HEALTH AND R	EHABILITATION CENTER		15	REET AOORESS, CITY, STATE, ZIP COOE 640 FOUNDERS PLACE HARLOTTESVILLE, VA 22902	<u> </u>	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ULO BE	(X5) COMPLETION DATE
F 157	edition on pages 77 medication Metform used for the manage dependent diabetes be managed with direference lists a U.S. Metformin stating, "potentially severe or metforminUse cat congestive heart fair management, particulated or acute C failure]" (3) The Drug Information edition on pages 57 Glimepiride as a sulused for the manage (non-insulin dependence of the management of the used in combination patients whose hywith a single agent, warnings for glimepiride as a sulused for the management of the management of the used in combination patients whose hywith a single agent, warnings for glimepirite agent. Warnings for glimepirite agent of the management of the used in combination patients whose hywith a single agent. Warnings for glimepirite decreased once daily with the final states, "Patients that or require decreased doses held to avoid glucose as recomm." These findings were findings were stated for the management of the mana	on Handbook for Nursing 13th 78 and 779 describes the nin as an antidiabetic agent gement of type 2 non-insulin s when hyperglycemia cannot iet and exercise. This S. Boxed Warning for "Lactic acidosis is a rare, but consequence of therapy with oution in patients with illure requiring pharmacologic cularly in patients with CHF (congestive heart on Handbook for Nursing 13th 73 and 574 describes alfonylurea antidiabetic agent gement of type 2 diabetes dent) along with diet and rence states glimepiride may ation with metformin or insulin typerglycemia is not controlled. This reference lists under poiride use, "All sulfonylurea of producing severe toglycemia is more likely to intake is deficientor when tose-lowering drug is used" the seglimepiride should be given first meal of the day and the tare NPO (nothing by mouth) and caloric intake may need thypoglycemiaMonitor mended by prescriber" (3)	F	157			
	administrator direct	for of nursing and cornorate					

FORM CMS-2567(02-99) Previous Versions Obsolete

nursing consultants on 6/8/16 at 4:50 p.m. and on

Event ID:XD6111

Facility IO; VA0417

If continuation sheet Page 12 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	19 LOV MEDICAVE	A MEDICAID SERVICES	·			VIB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA)DENT)F)CAT)ON NUMBER:	(X2) MUL A. BU)LD		(X3) DATE SURVEY COMPLETED	
		495420	B. W)NG			C 06/09/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREE	T ADDRESS, C)TY, STATE, Z)P CODE	7 00/00/2010
7011112 01 1	.,0.,02,,0,,,0				FOUNDERS PLACE	Ì
ALBEMA	RLE HEALTH AND R	EHABILITATION CENTER			RLOTTESVILLE, VA 22902	
(X4))D PREF)X TAG	(EACH DEF)C)ENCY	TEMENT OF DEF)C)ENC)ES / MUST BE PRECEDED BY FULL SC)DENT)FY)NG)NFORMAT)ON))D PREF); TAS	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 157	Continued From pa	ne 12	F 1	57	Tama Data	7/18/2 016
, , , , ,	•	-	, ,	J,		
	6/9/15 at 11:00 a.m				How the corrective actio	n will be
					accomplished for the res	sident(s)
	This was a complai	nt deticiency.			affected.	
		M. Lippincott Manual of Philadelphia: Wolters Kluwer			Patient #5's interview, included sections C for cognition, E	uding) for
	Health/Lippincott W	/illiams & Wilkins, 2014.			mood and J for pain was o	completed
					on 6/16/2016 to accurately	v assess
		c Acidosis? Lactic Acidosis.			patient's status.	,
	WebMD. 6/10/16.	http://www.webmd.com			paperit a status.	
	Elizabeth A. Tomsik	ce B., Brenda R. Lance and c. Drug Information Handbook on, Ohio: Lexi-Comp, 2011.			How corrective action w accomplished for those residents with the poter	itial to be
		•			affected by the same pr	actice.
	Foundation for Med 6/14/16.	Mayo Clinic. 1998 -2016. Mayo lical Education and Research.			Current patients' most rec will be reviewed by region	nal
		linic.org/diseases-conditions/h			consultant for accurate co	
F 270	483.20(g) - (j) ASSI	definition/con-20021103>	F 2	70	assessment interviews for	cognitive
SS=D	ACCURACY/COOF	RDINATION/CERTIFIED	Γ 2	270	patterns (Section C), moo (Section D) and pain (Sec	tion J).
	resident's status.	ust accurately reflect the			An OBRA and/or PPS ass will be scheduled for any identified with coding erro	patient s
	A registered nurse	must conduct or coordinate			in whom to one	PHILA
		with the appropriate			Measures in place to en	Juio
	participation of hea	lth prof e ssionals.			practices will not occur.	
	A registered nurse assessment is com	must sign and certify that the pleted.			Regional consultant will in MDS coordinator regardin MDS/RAI manual require	ıg
		o completes a portion of the sign and certify the accuracy of assessment.			accurately assessing and cognitive patterns, mood	coaing
	Under Medicare an	d Medicaid, an individual who				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event)D;XD6111

Facility)D: VA0417

If continuation sheet Page 13 of 56

PRINTED: 06/21/2016

	INCHI OI NEALIN	· · · · · · · · · · · · · · · · · · ·				FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED
		495420	B. WING	ì		C 06/09/2016
NAME OF	PROVIDER OR SUPPLIER		.1		ADDRESS, CITY, STATE, ZIP CODE	00/09/2016
					DUNDERS PLACE	
ALBEMA	ARLE HEALTH AND R	EHABILITATION CENTER		CHARL	LOTTESVILLE, VA 22902	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLÉTION
E 278	Continued From pa	vao 13	, س	070		
F 210		-	F 2	278		
		gly certifies a material and a resident assessment is			How the facility plans to	
		oney penalty of not more than			and ensure correction is ved and sustained.	acnie
		sessment; or an individual who			vou and sastamed,	
		gly causes another individual			Regional consultant will re	view five
		and false statement in a nt is subject to a civil money			MDS assessments weekly	for four
		than \$5,000 for each			weeks to ensure presence	
	assessment.	• •			complete minimum data s assessment as indicated f	
	611 * 1 II	1 de es estados de 1900 de 190			cognitive patterns, mood a	-
	material and false s	ent does not constitute a			Any deficient practice will	
	material and raise s	statoment.			re-education or disciplinar	
					as indicated.	
		NT is not met as evidenced			Administrator will report fir	
	by: Resed on staff into	rview and clinical record			the QA committee quarter tracking and trending.	ly for
		staff failed to ensure a			tracking and trending.	
		data set (MDS) assessment				
		its in the survey sample.				
		recent MDS with an nce date of 5/5/16 included no				
		resident's cognitive patterns,				
	mood or pain.	rooms oogavo pattorno,				
	The findings include	e:			s. i	
	Resident #5 was ac	dmitted to the facility on			<i>"</i>	
	2/19/16 with diagno	ses that included end stage				
		entia, diabetes, hypertension,				
		rt disease, heart failure, osy, hypothyroidism, pressure				
		ny. The MDS dated 2/26/16				
		#5 with short and long-term				
		and severely impaired				
	cognitive skills for o	decision-making.				

Resident #5's clinical record was reviewed on 6/8/16. The most recent MDS dated 5/5/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C		0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION		TE SURVEY MPLETED
		495420	B. WING	;		06	C 5/ 09/2016
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		15	REET ADDRESS, CITY, STATE, ZIP CODE 440 FOUNDERS PLACE HARLOTTESVILLE, VA 22902	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETION OATE
F 278	cognitive patterns, is Section C of the 5/5 cognitive skill, mem completed. There is responses to the bright questions (sections C0500) or any staff mental status (section C1000). Section D of the 5/5 mood issues was not documented responsinterview (section Diffeelings of depressing appetite, feeling back concentrating and restaff assessment of D0500) was not conwith dashes. Section J of the 5/5 regarding the resident There were no docupain interview quest J0500, J0600) regard frequency, pain effect intensity. The section indicators of pain (sincomplete and was On 6/8/16 at 4:30 p.	ment of the resident's mood or pain. 6/16 MDS for assessment of ory and recall was not were no documented ief interview for mental status C0200, C0300, C0400, assessment of the resident's ons C0700, C0800, C0900, 6/16 MDS for assessment of ot completed. There were no asses to the resident mood 0200) concerning interests, on, feeling tired, poor diabout self, trouble estlessness. The section for the resident's mood (section impleted and was marked only mented responses to the tions (sections J0300, J0400, right of the testion and pain on for staff assessment of ections J0800, J0850) was a marked only with dashes. In. the director of nursing	F:	278			
	(DON) was interview assessment section	wed about the missing as of Resident #5's MDS. On the DON stated the sections					

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with missing assessments were those that included interview questions. The DON stated if

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 15 of 56

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	& MEDICAID SERVICES	OMB NO. 09					
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING				ATE SURVEY OMPLETEO
		495420	B. WING			01	C 6/09/2016
	PROVIOER OR SUPPLIER	EHABILITATION CENTER		1540	EET AOORESS, CITY, STATE, ZIP COO D FOUNDERS PLACE ARLOTTESVILLE, VA 22902		
(X4) 10 PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE APP OEFICIENCY)	OULO BE	(X5) COMPLETION DATE
F 278	interview questions assessment should DON stated she did status, mood or pair completed on the 5. On page C-4 of the If the interview is status. Code -, dash in CC0400C. 2. Code 99 in the status. Code 1, yes in Code Code 1, yes in Code Conducted? 4. Complete the Status. On Page D-14 of the "Alternate means of used for residents werefuse or are unable Resident Mood Interiormation about the "Code 0, no: if the rany pain in the 5-datus in the reasident received printerventions. If code complete. Skip to Status."	t able to respond to the then the sections for staff have been completed. The I not know why the mental in assessments were not /5/16 MDS. MDS/RAI manual, it reads, "opped, do the following: 00400A, C0400B, and ummary score in C0500. 0600 Should the Staff intal Status (C0700-C1000) be aff Assessment for Mental e MDS/RAI manual, it reads, f assessing mood must be who cannot communicate or e to participate in the PHQ-9© riview. This ensures that heir mood is not overlooked." MDS/RAI manual, it reads, esident responds "no" to by look-back period. Code 0, on for no pain is that the	F 2	278			

AND J0700.

pain at any time during the look-back period. If coded 1, proceed to items J0400, J0500, J0600

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	(2 LOK MEDICAKE	& MEDICAID SERVICES				<u>O</u>	<u>VIB NO. 0938-0391</u>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495420	B. WING				C 06/09/2016		
NAME OF R	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP C	ODE			
				1540	FDUNDERS PLACE				
ALBEMA	RLE HEALTH AND RI	EHABILITATION CENTER		CHA	RLOTTESVILLE, VA 22902				
	SILMAND CTA	TEMENT OF DEFICIENCIES							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE COMPLETION		
F 278	Continued From pa	ige 16	F2	278					
	unable to answer, d nonsensical respon Staff Assessment for	answer: if the resident is does not respond, or gives a nse. If coded 9, skip to the or Pain beginning with or Possible Pain item (J0800)."							
F 279		and corporate nursing meeting on 6/8/16 at 4:50	F:	279					
SS=D	COMPRÉHENSIVE A facility must use t	CARE PLANS the results of the assessment and revise the resident's	1 2		F279 How the corrective ac accomplished for the affected. Patient #2 and #3 no lo	ctio n w e re s ide	e nt (s)		
	plan for each reside	evelop a comprehensive care ent that includes measurable etables to meet a resident's			at Albemarle Health ar Rehabilitation Center.		:		
	medical, nursing, ar needs that are iden assessment.	nd mental and psychosocial tified in the comprehensive			How corrective action accomplished for the residents with the poaffected by the same	ose otential	to be		
	to be furnished to a highest practicable psychosocial well-b §483.25; and any sebe required under § due to the resident's	t describe the services that are attain or maintain the resident's physical, mental, and seing as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment.)			Current patients will be ensure a comprehens has been developed to diabetic management impairment and care urinary catheter. A cocare plan will be developed to the review of the care by the review of the care by the review of the care by the review of the care plan will be developed to the review of the care by the care	pe revies sive car to include t, skin of a Folo eloped a	wed to e plan de ley ensive		
	This REQUIREMEN	NT is not met as evidenced							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XD6111

Facility ID: VA0417

(f continuation sheet Page 17 of 56

PRINTED: 06/21/2016

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION 3	CON	TE SURVEY MPLETED
		495420	8. WING	à			C 5/ 09/2016
NAME OF F	PROVIDER OR SUPPLIER		ا ـــــ	_	STREET ADDRESS, CITY, STATE, ZIP CODE		/09/2016
				1	1540 FOUNDERS PLACE		
ALBEMA	RLE HEALTH AND R	EHABILITATION CENTER		1	CHARLOTTESVILLE, VA 22902		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD 8E	(X5) COMPLETION DATE
F 279	Continued From pa	ge 17	F2	279	Measures in place to en practices will not occur		
	and complaint investo develop a compr 6 residents in the standard freated daily with had no care plan demanagement and had regarding care of low 2. Resident #3 had regarding care of a The findings included 1. Resident #2 had	gnosed with type 2 diabetes th oral antidiabetic medicines, eveloped regarding diabetic ad no care plan developed wer leg edema with blistering. no care plan developed Foley urinary catheter. e: no care plan regarding ent and care of lower leg			Staff Development Coord or/designee will in-service nurses on policy and processes on policy and processes on policy and processes on policy and processes of patient's mental and payoneeds as well as any servequired and identified in comprehensive assessmental and psychosocial servicing will include devinitial care plan on admist ADLs, pain, skin, fall risk and any other pertinent of such as diabetic manage care of a foley urinary care	e charge cedure for initiation mission edical, chosocial vices the ent to nursing, needs. In eloping are sion for are areas ement and	1- n
	Resident #2 was ac 4/12/16 and dischar on 5/5/16. Diagnos slatus post hernia re type 2 diabetes, hyp hypertension, hypox history of venous th disorder, atheroscle valve stenosis and a data set (MDS) date	Imitted to the facility on rged to the emergency room es for Resident #2 included epair, heart failure, edema, pertension, pulmonary kemia, acute kidney injury, rombosis, major depressive erotic heart disease, aortic arthropathy. The minimum ed 4/19/16 assessed Resident impaired cognitive skills.			How the facility plans to and ensure correction achieved and sustained. Unit Manager/designee with the comprehence of a roley diffied in the roley diffied in the comprehence of a roley diffied in the roley dif	o moni to is d. vill review v orders r weeks to being e been	

Resident #2's closed clinical record was reviewed

on 6/8/16. The record documented the resident had a diagnosis of type 2 diabetes. A physician's

order dated 4/12/16 was documented for the

(milligrams) to be administered 3 times per day

antidiabetic medication Metformin 500 mg

assessment to meet a patient's medical, nursing, mental and

development of comprehensive

psychosocial needs for

care plan.

PRINTED: 06/21/2016

		AND HOMAN SERVICES			*	FORM	APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O		. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY IPLETED
		495420	B. WING				C (00/2046
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	09/2016
					10 FOUNDERS PLACE		
ALBEM,	ARLE HEALTH AND R	EHABILITATION CENTER			IARLOTTESVILLE, VA 22902		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	1X5) COMPLETION DATE
F 279	Continued From pa	ne 18	F 2	70			
, 2,0		type 2 diabetes. The resident	1 2	.19	Any deficient practice will re	esult in	
		n's order for the antidiabetic			re-education or disciplinary		
ı		de 2 mg to be administered			as indicated.		
	daily for the treatme	ent of type 2 diabetes. The					
		on administration records			Director of Nursing will repo		
		d these medications were			findings to the QA committee		
		dered from 4/12/16 through The record assessed the			quarterly for tracking and tr	enaing.	
		for leg wraps and elevation to					
		of her lower extremities in					
		d blisters on her legs/feet.					·
	to include problems regarding the reside made no mention the included no interverside effects from he medications. The orgoals and/or interverside to include the included no interverside effects from he medications.	plan (revised 4/21/16) failed in goals and/or interventions ent's diabetes. The care plan he resident was diabetic and intions regarding any possible er daily oral antidiabetic care plan listed no problems, entions regarding the remity edema or care her blistered skin.					
	(DON) was interviet plan. The DON state developed for residual admission. The DO the care plan were diagnoses, nursing issues. The DON shad a care plan registated the resident	.m. the director of nursing wed about Resident #2's care ted care plans were ents within 24 hours of their DN stated problem areas on identified based upon assessments and resident stated the resident should have arding diabetes. The DON had physician orders for care ema but these items were not			A ^d		

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These findings were reviewed with the

administrator, director of nursing and corporate nurse consultants on 6/9/16 at 11:00 a.m.

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 19 of 56

PRINTED: 06/21/2016

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		<u>{</u>			С
		495420	B. WING	<u> </u>	06/09/2016
NAME OF	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	
AI REM	ARIE HEALTH AND R	EHABILITATION CENTER		1540 FOUNDERS PLACE	
ALD#1111	WEE HEALTHAID I		1	CHARLOTTESVILLE, VA 22902	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFII TAG		BE COMPLETION
F 279	Continued From pa	ge 19	F2	279	
	develop a compreh Foley Catheter care Resident # 3 was a 3/10/16. Diagnoses are not limited to pr joint, chronic pain, r Foley catheter-a fle urethra and into the aftercare following j type II diabetes mel A clinical record rev and 6/9/16. Resider	3 the facility staff failed to ensive Care Plan to include e. dmitted to the facility on some for Resident # 3 included but esence of right artificial knee retention of urine (requiring a xible tube passed through the bladder to drain urine), joint replacement surgery and litus (high blood sugar). riew was conducted on 6/8/16 at # 3's Admission Minimum assessment protocol) with an			
	Resident #3 with no indicated by a BIMS Status) of 15. In ac Resident # 3 required Activities of Daily Litransferring, dressin ROM (Range of Mo	ence Date of 3/17/16 coded o cognitive impairment as 6 (Brief Interview Mental dition, the MDS coded ing extensive assistance for ving care (ambulating, and bathing). Documented tion) on the MDS indicated			

According to the physician orders summary dated 3/1/16 through 6/30/16 presented by the facility staff, three orders were written on 3/10/16 regarding Foley Catheter Care for resident #3.

a catheter was in use upon admission.

The first order documented, "Change Foley Catheter q [every] 30 days and PRN [as needed]" with an order date of 3/10/16 but with a status of "discontinued" with no start or end date.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: XO6111

Facility IO: VA0417

If continuation sheet Page 20 of 56

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) D.	(X3) DATE SURVEY COMPLETED		
		495420	B. WING			0	C 6/09/2016		
	PROVIDER OR SUPPLIER ARLE HEALTH AND R	EHABILITATION CENTER		1540	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOUNDERS PLACE ARLOTTESVILLE, VA 22902				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 279	shift" also with an oa status of "discontidate. The third order door (specify size and badate of 3/10/16 but with no start or end A clinical nursing not the Foley Catheter of the Care Plan days for Resident #3, it would be resident [#3] has in diagnosis of urinary interventions, "Moniand frequency" and pain/discomfort due Care Plan was Fole part of the intervent "Resident will be/resident wil	locumented, "Foley care q rder date of 3/10/16 and with inued" with no start or end umented, "Foley Catheter alloon)" again with an order with a status of "discontinued" date. Interest of the dated 3/25/16 documented was removed. Indeed 3/10/16 through 3/30/16 was documented that, and welling Catheter for a retention" but only listed two itor for discomfort on urination "Monitor/document for a to catheter." Nowhere on the ey Catheter Care mentioned as ions to obtain the goal, main free from uma through review date by". In ON (Administration #2) in an at 9:30 a.m. it is a standard of inderstood) to perform Foley ier is present and to care plan all of not produce any additional	F 2	.79					
	was included in the								
	The facility administ	tration was informed of the							

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findings during a briefing on 6/9/16 at approximately 11:00 am. The facility did not

Event ID; XD6111

Facility ID: VA0417

If continuation sheet Page 21 of 56

JUL 0 1 2016
VDH/OLC

	MENT OF HEALTH	AND HUMAN ERVICES & MEDICAID SERVICES			(FORM A	06/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		(X3) DATE	
		495420	B. WING				. C) 9/2016
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY	, STATE, ZIP CODE		
ALBEMA	RLE HEALTH AND RI	EHABILITATION CENTER			FOUNDERS PLAC ARLOTTESVILLE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	(EACH CORRECTED CROSS-REFEREIT	PLAN OF CORRECT CTIVE ACTION SHOL NCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279		information about the findings.	F 2	79		Date for the re		
F 281 SS=G	483.20(k)(3)(i) SER PROFESSIONAL S The services provid	VICES PROVIDED MEET	F 2	81	at Albema	and #3 no long rle Health and tion Center.	jer reside	
	by: Based on staff interclinical record reviet the facility staff failer standards of nursing residents in the sunfailed to assess bloom abrupt change in hypoglycemia (harm staff failed to docum controlled medication emergency drug sugar medication for of her blood sugar leincreased confusion of appetite, worseni output. Resident #2 antidiabetic medication and the physician w	rview, document review, w and complaint investigation, of to follow professional g practice for two of 6 vey sample. Facility staff od sugar levels in response to a condition resulting in severe a) for Resident #2. Facility ment the administration of a condition of a condition of a condition of a condition resulting in severe a) for Resident #3. Ignosed and treated with daily diabetes, had no assessment evel after experiencing a, altered mental status, lacking edema and lack of urinary 2 continued to be administered tions after she refused meals as not notified that no urine catheterized for a urine			accompliates affected to Current passince 6/9/2 identify post to meet an standards departed such as: 1. A post factor of the control of the	ective action we shed for those with the poter by the same properties atients progress 2016 will be revotential services and/or follow progress from appropriates assessing the paraperty and in a ashion ollowing physic communicating in bout the patient adhering to facility and procedure procedure procedure appropriation in the ecord	ntial to be ractice. Is notes viewed to sthat failed fessional ctice or e care atient timely ian orders information to typolicy	i

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sample. The resident was sent to the emergency

unresponsive upon arrival to the emergency room

with severe hypoglycemia (low blood sugar). The

resident was admitted to the hospital intensive

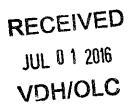
room at family request and was assessed as

Event ID: XD6111

Facility ID: VA0417

nurse,

If continuation sheet Page 22 of 56



6. Administering medications

as ordered.

Any identified areas of non-

compliance will result in re-

education of the involved charge

PRINTED: 06/21/2016 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391	
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) OA	(X3) OATE SURVEY COMPLETEO	
		495420	B. WING	i		06	C 5/09/2016	
NAME OF	PROVIOER OR SUPPLIER			STREE	ET AOORESS, CITY, STATE, ZIP COOE			
ALBEMA	ARLE HEALTH AND R	EHABILITATION CENTER		!	FOUNDERS PLACE RLOTTESVILLE, VA 22902			
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	ILO BE	(X5) COMPLETION DATE	
F 281	and lactic acidosis t	ge 22 died due to acute renal failure that failed to respond to	F2	281	Measures in place to ensu practices will not occur.	ıre		
	blood sugar (glucos associated with the signs and symptom recognized and trea untreated hypoglyce loss of consciousne treatment of hypoglyget your blood sugarange - about 70 to [mg/dL]either with medications." (4) 2. Facility staff failed information (to whose				Staff Development Coordinatesignee will in-service chanurses on providing service meet professional standard nursing practice and/or that not depart from appropriate such as: 1. Assessing the paties properly and in a tiresfashion 2. Following physician 3. Communicating information in facility and procedure 4. Adhering to facility and procedure 5. Documenting approximformation in the management of the property of the procedure of the procedu	rge s that s of does care ent nely orders ormation colicy epriate aedical		
	The findings include				Administering medial as ordered.	Jauons		
	oral medication for of her blood sugar lincreased confusion of appetite, worseni output. Resident #2 antidiabetic medica and the physician w	gnosed and treated with daily diabetes, had no assessment evel after experiencing n, altered mental status, lacking edema and lack of urinary 2 continued to be administered tions after she refused meals as not notified that no urine catheterized for a urine			A ^f			

sample. The resident was sent to the emergency room at family request and was assessed as unresponsive upon arrival to the emergency room with severe hypoglycemia (low blood sugar). The

DEPARTMENT OF HEALTH AND HUMAK

PRINTED: 06/21/2016

CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	EDICAID SERVICES PROVIDER/SUPPLIER/SUIA IDENTIFICATION NUMBER: 495420	A. BUILDII	CIPLE CONSTRUCTION NG	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	OENTIFICATION NUMBER:	A. BUILDII			
	495420			COMPLETED	
		B. WING		C 06/09/2016	
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2010	
	11 17 47 A. L.		1540 FOUNDERS PLACE		
ALBEMARLE HEALTH AND REHAL	BILITATION CENTER		CHARLOTTESVILLE, VA 22902		
(X4) ID SUMMARY STATEME PREFIX (EACH DEFICIENCY MUS' TAG REGULATORY OR LSC IDE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROF DEFICIENCY)	DBE COMPLÉTION	
of her blood sugar level increased confusion, alto of appetite, worsening experite, wo	on the hospital intensive due to acute renal failure ailed to respond to and treated with daily etes, had no assessment after experiencing ered mental status, lack dema and lack of urinary attinued to be administered after she refused meals of notified that no urine eterized for a urine as sent to the emergency and was assessed as all to the emergency room is (low blood sugar). The of the hospital intensive due to acute renal failure ailed to respond to the emergency room in the acute renal failure ailed to respond to the emergency room in the acute renal failure ailed to respond to the emergency room in the acute renal failure ailed to respond to the emergency room in the acute renal failure ailed to respond to the emergency room in the acute renal failure ailed to respond to the emergency room in the acute renal failure ailed to respond to the emergency room in the failure ailed and treated with daily etes, had no assessment after experiencing	F 28	How the facility plans to rand ensure correction is achieved and sustained. Director of Nursing/designereview 24 hour report and rorders five times a week for weeks to identify any depart from appropriate care relatifollowing professional standaursing practice. Unit Manager/designee will controlled medications remfrom the stat box weekly for weeks to ensure appropriate administration/documentation the medication was removed the stat box and signed on eMAR when administered. Any deficient practice will rere-education or disciplinary as indicated. Director of Nursing will report findings to the QA committed quarterly for tracking and tree.	e will new r four ture ng to dards of review oved r four e on as on that ed from patient's sult in action	

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and the physician was not immediately notified That no urine was obtained when catheterized for a urine sample. The resident was sent to the

Event ID: XD6 t11

Facility ID: VA0417

If continuation sheet Page 24 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING C 495420 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X3) DATE SURV. COMPLETE C HARLOTTESVILLE, VA 22902	CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
ALBEMARLE HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING				1 ' '			(X3) D/	ATE SURVEY
NAME OF PROVIDER OR SUPPLIER ALBEMARLE HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902 ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) ID PROVIDER'S PLAN OF CORRECTION (X6) ID PROVIDER'S PLAN OF CORRECTION (X7) ID PROVIDER'S PLAN OF CORRECTION (X8) I			495420	B. WING			0	C 6/09/2016
(7.47).5			EHABILITATION CENTER		1540	FOUNDERS PLACE		
	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETION DATE
F 281 Continued From page 24 emergency room nine hours after the change of condition at family request and was assessed as unresponsive upon arrival to the emergency room with severe hypoglycemia (low blood sugar). The resident was admitted to the hospital intensive care unit and later died due to acute renal failure and lactic acidosis that failed to respond to treatments. Resident #2 was admitted to the facility on 4/12/16 and discharged to the emergency room on 5/5/16. Diagnoses for Resident #2 included status post hernia repair, heart failure, edema, type 2 diabetes, hypertension, pulmonary hypertension, hypoxemia, acute kidney injury, history of venous thrombosis, major depressive disorder, atherosclerotic heart disease, aortic valve stenosis and arthropathy. The minimum data set (MDS) dated 4/19/16 assessed Resident #2 with moderately impaired cognitive skills. Resident #2's closed clinical record was reviewed on 6/8/16. A physician's order dated 4/12/16 was documented for the anticiabetic medication Metformin 500 mg (milligrams) to be administered 3 times per day for the treatment of type 2 diabetes. The resident also had a physician's order for the anticiabetic medicine Glimepride 2 mg to be administered adily for the treatment of diabetes. The resident served administered and main streat on records (MARs) documented the full main served when the resident's medication administration records (MARs) documented these medications were administered as ordered from 4/12/16 through 9:00 a.m. on 5/5/16. Nursing notes documented the following regarding a change in the resident's condition starting on 5/5/16.	F 281	emergency room ni condition at family runresponsive upon with severe hypogly resident was admitt care unit and later of and lactic acidosis it treatments. Resident #2 was ac 4/12/16 and dischart on 5/5/16. Diagnos status post hernia rutype 2 diabetes, hyphypertension, hypothistory of venous the disorder, atheroscle valve stenosis and data set (MDS) date #2 with moderately. Resident #2's close on 6/8/16. A physicide documented for the Metformin 500 mg (administered 3 time type 2 diabetes. The physician's order for Glimepiride 2 mg to treatment of diabete administration recommedications were a 4/12/16 through 9:0. Nursing notes docuregarding a change	ine hours after the change of request and was assessed as arrival to the emergency room yeemia (low blood sugar). The ted to the hospital intensive died due to acute renal failure that failed to respond to dmitted to the facility on reged to the emergency room ses for Resident #2 included repair, heart failure, edema, pertension, pulmonary xemia, acute kidney injury, prombosis, major depressive erotic heart disease, aortic arthropathy. The minimum ed 4/19/16 assessed Resident impaired cognitive skills. Red clinical record was reviewed sian's order dated 4/12/16 was a antidiabetic medication (milligrams) to be as per day for the treatment of the resident also had a for the antidiabetic medicine to be administered daily for the es. The resident's medication rds (MARs) documented these administered as ordered from 10 a.m. on 5/5/16.		81			

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5/5/16 at 12:52 a.m. -"Pt [patient] alert, confused.

Event ID:XD6111

Facility ID: VA0417

If continuation sheet Page 25 of 56

JUL U 1 2016

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	<u> MB NO</u>	<u>. 0938-0391</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	CON	TE SURVEY MPLETED
		495420	B. WING	;	and the second s	1	C /09/2016
NAME OF	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
ALBEMA	ARLE HEALTH AND R	EHABILITATION CENTER		į.	40 FOUNDERS PLACE HARLOTTESVILLE, VA 22902		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 281	Continued From pa	ge 25	F:	281			
	Insisting that she be while being pushed for dinner. Fluid int urinary frequency, r [bathroom]. Insiste	e able to put her feet on floor in wheelchairAppetite poor ake fairC/O [complained of] refused to go into bathroom d on using bedpan, but Call to MD [physician]"	·				
	5/5/16 at 4:32 a.m "resident is in bed noted with some altered mental status, she still verbalizes and is responding to questions appropriately especially when responding to family, v/s [vital signs] 97.9, 100, 20, 110/75 [temperature, pulse rate, respiration rate, blood pressure] and oxygen saturation 93% on room air. MD contacted and ordered UA [urinalysis], C&S [culture and sensitivity] catheterized x 1 without any result, at this time, no s/s [signs/symptoms] of pain noted"						
	5/5/16 at 6:11 a.m. administered for pa agitation"	- Tramadol 50 mg in, "resident noted with					
	mental status, incre extremities, pain, a communication, ab upper extremities, a mouthBreath sou monitored. 120/80 pressure, oxygen s	- "Resident displays altered eased edema of upper and decreased verbal normal movements of the and facial gestures of the ands, and vitals [vital signs], 95%, 89, 95.4, 20 [blood aturation, pulse rate, ation rate]Transfer to request."					
	the resident on mos from 50% to 100 %	intake records documented st days since admission ate of meals until the evening of ords documented the resident					

refused dinner on 5/4/16 and refused breakfast

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	,		. 0	<u>MB NO. /</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495420	B, WING			0 6 /0) 9/2016
NAME OF	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CDDE		
	DIFTON ALTER AND D	CITABILITATION OFNITED	-	1540	FOUNDERS PLACE		
ALBEMA	KLE HEALIH AND K	EHABILITATION CENTER		CH/	ARLOTTESVILLE, VA 22902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ae 26	F 2	281			
	•	ident continued to receive the		,			
		tions Metformin on 5/4/16 at					
		ide on 5/5/16 at 8:00 a.m. and					
		on 5/5/16 at 9:00 a.m. There					
		to the physician concerning					
	the resident's lack of	от тоод глаке.					
	A change in condition	on form dated 5/5/16 at 10:04					
	a.m. documented F	Resident #2 was assessed with					٠
		us, edema and uncontrolled					
		the morning of 5/5/16. The					
		dent's vital signs as: blood , pulse rate of 89, respiration					
		perature of 95.4. The form					
		ne resident's oxygen saturation					
		m air. The space for the most					
		se level was blank. The					
		he resident had an abrupt					
		with increased confusion,					
		eased level of consciousness. physician was notified of the					
		n condition on 5/5/16 at 8:15					
		de no mention the resident had					
		eterized or had not eaten					
	since lunch on 5/4/	16.					
		ssment of the resident's blood					
	sugar level in respo	onse to the change in					
		review of Resident #2's clinical					
		I no routine monitoring of the gar levels since her admission.					
		d on 4/26/16, signed by the					
		documented the resident's					
		as low with a reading of 64					
	mg/dL (milligrams/d	leciliter) with a normal range					
		There were no physician					
		monitor the resident's blood					
	sugar upon admission, in response to the lab						

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work or at the time her condition changed on

Event ID: XD6111

Facility ID: VAD417

If continuation sheet Page 27 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

	INCHI OF CIERCETC	THE HOW WITCENTION			*	FUK	M APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-0391	
NAME OF PROVIDER OR SUPPLIER ALBEMARLE HEALTH AND R (X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY REGULATORY OR LE F 281 Continued From pa 5/5/16. The resident's care included no probler regarding diabetes, mention the residen no interventions reg effects from her da medications. Hospital notes docu the emergency room was diagnosed with Emergency room in the resident was un hospital. Notes do of AMS [altered me [emergency medica [patient's] family ch and found her with They [EMS] note a and notes that she Diagnoses listed or assessment include kidney injury, altere disarray most likely lactic acidosis, urin		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE S COMPLE		
		495420	B. WING	_		01	C 6/09/2016	
NAME OF F	PROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE			
41.05014	DI ELIEALTII AND D	CHARLETATION CENTER		1	1540 FOUNDERS PLACE			
ALBENIA	ALBEMARLE HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 281 Continued From page 27 5/5/16. The resident's care plan (revised 4/21/16) included no problems, goals and/or interventions regarding diabetes. The care plan made no mention the resident was diabetic and included no interventions regarding any possible side effects from her daily oral antidiabetic		_ (CHARLOTTESVILLE, VA 22902				
PREFIX	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION AME OF PROVIDER OR SUPPLIER ALBEMARLE HEALTH AND REHABILITATION (XA) ID SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED TO REGULATORY OR LSC IDENTIFYING F 281 Continued From page 27 5/5/16. The resident's care plan (revised included no problems, goals and regarding diabetes. The care plan mention the resident was diabetino interventions regarding any perfects from her daily oral antidial medications. Hospital notes documented the resident was unresponsive unto hospital. Notes documented, " of AMS [altered mental status] [emergency medical services] to [patient's] family checked on pto a and found her with an altered mental status] [emergency medical services] to [patient's] family checked on the initial emassessment included severe hypological services] to page 18	' MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR OEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 281	•	ge 27	F2	281				
	included no probler regarding diabetes. mention the resider no interventions reg effects from her da	ns, goals and/or interventions The care plan made no nt was diabetic and included garding any possible side						
	the emergency room was diagnosed with Emergency room in the resident was un hospital. Notes do of AMS [altered me [emergency medica [patient's] family chand found her with They [EMS] note a and notes that she Diagnoses listed or assessment include kidney injury, alteredisarray most likely lactic acidosis, urina acute liver injury, co diabetes and chron emergency record or resident's blood glu undetectable upon and physical dated "Fingerstick glucose"	m on 5/5/15 at 10:45 a.m. and a severe hypoglycemia. otes dated 5/5/16 documented presponsive upon arrival to the cumented, "chief complaint intal status]Per EMS all services]they state that pt's ecked on pt about 3 hours ago an altered mental status. blood sugar of 14 en route has received glucagon" at the initial emergency room ed severe hypoglycemia, acuted mental status, metabolic due to acute renal failure, ary tract infection, suspected pronary artery disease, type 2 fic systolic heart failure. The dated 5/5/16 listed the cose (sugar) level was arrival. The hospital history 5/5/16 documented, et 14 per EMS. Patient not						

Most likely cause of hypoglycemia is decreased po [oral] intake combined with oral hypoglycemic medications (Glimepiride, metformin)." The

history and physical dated 5/5/16 defined

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION		ATE SURVEY OMPLETED			
:		495420	B, WING	·		C	C 06/09/2016			
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	•	154	REET ADDRESS, CITY, STATE, ZIP CODE 0 FOUNDERS PLACE ARLOTTESVILLE, VA 22902	•				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATDRY OR L	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE				
F 281	included high sodiu level of 6.2, high ph setting of AKI [acute acidosis. Most likel failure" (sic) The resident was a died on 5/7/16 after treatments. The hodated 5/7/16 docum history of coronary heart failure, type 2 and presented to the with altered mental the resident was in surgical repair for a documented, "A fet #2] began to have a morning of admission remembers and [an normally happens at came to visit at 8:15 lying in bed moanin EMS was called an ambulance. In the have a glucose of 1 and taken to the ED where repeated fing measureInitial lab	as abnormal lab results that m level of 125, high potassium to sphorus level of 6.6 " all in a exidney injury] and lactic by etiology is acute renal distributed to the hospital and exhe failed to respond to expital discharge summary mented the resident had a lartery disease, chronic systolic diabetes and hypertension the emergency room on 5/5/16 status. The summary stated the nursing facility following thernia. The summary ew days ago, she [Resident a decreased appetite. On the large on, patient states that she explained her mother gout otherwise unresponsive. It is a decreased appetite on, patient states that she explained her mother gout otherwise unresponsive. It is a decreased appetite on, patient states that she explained her mother gout otherwise unresponsive. It is a decreased appetite on, patient states that she explained her mother gout otherwise unresponsive. It is a decreased appetite on, patient states that she explained her mother gout otherwise unresponsive. It is a decreased appetite on the control of the contr		281						
	disarray as well as l discharge summary resident was admitt care unit for treatme [Resident #2's] stay	ey injury] and metabolic lactic acidosis" The dated 5/7/16 documented the led to the medical intensive ent and listed, "During her declared lactic acidosis failed to eveloped oliguric renal failure								

despite volume resuscitation...Despite

interventions she failed to improve...dialysis was

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES					01	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUİLD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495420	B. WING				C 06/09/2016
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		154	REET ADDRESS, CITY, STATE 10 FOUNDERS PLACE IARLOTTESVILLE, VA		
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F 281	[Resident #2] was to measures. Cause failure and refractors. The nurse caring for morning hours on available for intervioldirector of nursing (Resident #2's chand DON stated there wordered on 4/26/sugar checks requided the lack of urine of the lack of urine of the lack of urine on 6/8/16 at 9:40 at that cared for Resident's blood in condition. The Neen on oral diabet of the NP stated she physician about who have been ordered diabetic medicines should have continue ating, the NP stated held the diabetic more not eating. The NP aware the resident stated, "The nurses are the resident stated, "The nurses are all the diabetic more stated, "The nurses are all the stated and reference the resident stated, "The nurses are all the stated and reference the resident stated, "The nurses are all the stated and reference the resident stated, "The nurses are re	S [2016] at which time ransitioned to comfort care of death is acute oliguric renal ry lactic acidosis." Or Resident #2 during the early 5/5/16 was on leave and not ew. On 6/8/16 at 9:10 a.m. the (DON) was interviewed about ge in condition on 5/5/16. The vere no physician orders to esident #2's blood sugar levels in 5/5/16 other than the lab 16. The DON stated blood red a physician's order. The ysician was called but there he physician was made aware output or lack of food intake. I.m. the nurse practitioner (NP) dent #2 was interviewed about I sugar monitoring and change IP stated Resident #2 had icic medicines "for a long time." could not speak for the en blood sugar checks should. When asked if the oral (Metformin, Glimepiride) used when the resident was not ed she probably would have edicines if she knew she was a stated she was not made was refusing meals. The NP is have to let us know."	F 2	281			
		.m. the registered nurse was interviewed about any					

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assessment of the resident's blood sugar level or notification concerning the lack of urine output

Event ID:XD6111

Facility ID: VA0417

If continuation sheet Page 30 of 56

JUL U 1 2016 VDH/OLC

PRINTED: 06/21/2016

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·		OMB NO. 0938-0391
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2 MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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INAMIL OF	THOUBER OR SOFT EIER				
ALBEM/	ARLE HEALTH AND R	EHABILITATION CENTER		1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902	
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F 281	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		F 2	81	

her decline was related to her heart failure. The physician stated the resident's right sided heart failure caused liver congestion which made treatments to correct abnormal blood sugars difficult. When asked about the resident's altered mental status and documented change in

condition on 5/5/16, the physician stated, "Acutely I would have expected them [nurses] to assess [blood sugar level]." The physician stated, "In retrospect we should have been monitoring her [Resident #2's] blood sugars." When asked about any knowledge that the resident was catheterized and had no urine output at 4:32 a.m.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER ARLE HEALTH AND RI	EHABILITATION CENTER		STREET ADDRESS, CITY, S 1540 FOUNDERS PLACE CHARLOTTESVILLE, V		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIA FICIENCY)	
F 281	any notification abo Concerning notifica output, the physicia thought a change in call." The physiciar discharge summary diagnosis of "refrac physician stated ref blood sugar that wo and this was most li severe heart failure The physician state would not have cha treatment of the low failure but stated ag blood sugar assess became acutely ill. resident's blood sug checked especially failure, the physicial explanation of why levels were not mor On 6/8/16 at 4:10 p about the expected no urine was obtain DON stated nurses physician about not at 9:10 a.m. the DO standing orders reg DON stated the fact diabetics. The DON	ician stated he did not recall ut lack of urine output. tion about the lack of urine n stated, "I would have a condition would create a new as shown the hospital of and asked to define the tory hypoglycemia." The fractory hypoglycemia was low ould not respond to treatments itsely related to the resident's and subsequent organ failure. If the total the tesident's outcome nged even with earlier or blood sugar due to her organ gain he would have expected a ment when the resident When asked why the gar level was not routinely with her history of heart in stated he had no Resident #2's blood sugar		81		

The Lippincott Manual of Nursing Practice 10th edition on page 952 describes diabetes mellitus

as "a metabolic disorder characterized by

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

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				1540 F	OUNDERS PLACE			
ALBEMA	RLE HEALTH AND R	EHABILITATION CENTER		CHAF	RLOTTESVILLE, VA	22902		
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F 281	production, secretic this reference state known as non-insul mellitus or adult-on by a combination of insulin deficiency' page 945, "Accurate blood glucose assist daily management glucose monitoring of medicationand episodes of hypogly determine approprison pages 962 and 9	results from defective insuling, or utilization." Page 942 of stype 2 diabetes is "formally in-dependent diabetes set diabetes mellituscaused insulin resistance and relative. This reference stated on eletermination of capillary at patients in the control and of diabetes mellitus. Blood helps evaluate effectiveness assists in the evaluation of remia and hyperglycemia to ate treatment." This reference 1663 includes in standards of Closely monitor blood glucose oglycemiaTreat	F 2	81				
	edition on page 795 (AKI) as "a clinical sudden decline in redisturbances in fluid acid-base homeostaregulation, erythrop production], and mifrequently associate [blood, urea, nitroge (less than 500 mL [in hyperkalemia [eleva sodium and fluid reduction acid made by the behave enough oxyge pressure, heart failu	ual of Nursing Practice 10th is defines acute kidney injury syndrome in which there is a senal function. This results in and electrolyte balance, asis, blood pressure olesis [red blood cell neral metabolism. It is need with an increase in BUN en] and creatinine, oliguria milliliters] urine/24 hours), ated sodium level], and tention." (1)						

FORM CMS-2567(02-99) Previous Versians Obsalete

(2)

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 33 of 56

JUL 0 1 2016
VDH/OLC

PRINTED: 06/21/2016

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NAME OF	PROVIDER OR SUPPLIER		'	STREET AOORESS, CITY, STATE, ZIP COOE	
ALBEMA	RLE HEALTH AND R	EHABILITATION CENTER		1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902	
(X4) IO PREFIX TAG	(EACH OFFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPR OEFICIENCY)	JLO BE COMPLETION
F 281	Continued From pa	age 33	F 28	B 1	
	edition on pages 77 medication Metforn used for the manage dependent diabetes be managed with deference lists a U. Metformin stating, potentially severe cometformin Use cas congestive heart far management, particularly and congestive heart far management, particularly (3) The Drug Informaticular on pages 57 Glimepiride as a survey of the management	on Handbook for Nursing 13th 78 and 779 describes the nin as an antidiabetic agent gement of type 2 non-insuling when hyperglycemia cannot iet and exercise. This S. Boxed Warning for Lactic acidosis is a rare, but consequence of therapy with aution in patients with illure requiring pharmacologic cularly in patients with CHF [congestive heart] on Handbook for Nursing 13th 73 and 574 describes alfonylurea antidiabetic agent gement of type 2 diabetes dent) along with diet and arence states glimepiride may ation with metformin or insuling typerglycemia is not controlled.			
	with a single agent, warnings for glimer drugs are capable of hypoglycemia. Hypoccur when caloric	This reference lists under piride use, "All sulfonylurea of producing severe poglycemia is more likely to intake is deficientor when cose-lowering drug is used"			

This reference states glimepiride should be given once daily with the first meal of the day and states, "Patients that are NPO [nothing by mouth] or require decreased caloric intake may need doses held to avoid hypoglycemia...Monitor glucose as recommended by prescriber..." (3)

These findings were reviewed with the

administrator, director of nursing and corporate

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
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NAME OF F	PRDVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CDDE		
ALBEMA	RLE HEALTH AND RI	EHABILITATION CENTER			540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902		
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F 281	Continued From pa	ge 34	F 2	281			
	•	on 6/8/16 at 4:50 p.m. and on					
	This was a complain	nt deficiency.					
	Nursing Practice. F	M. Lippincott Manual of Philadelphia: Wolters Kluwer lilliams & Wilkins, 2014.					
	2) What is Metabolic Acidosis? Lactic Acidosis. WebMD. 6/10/16. http://www.webmd.com						
	Elizabeth A. Tomsik	ce B., Brenda R. Lance and Drug Information Handbook n, Ohio: Lexi-Comp, 2011.					
	Foundation for Med 6/14/16.	Mayo Clinic. 1998 -2016. Mayo ical Education and Research. inic.org/diseases-conditions/h					
	ypoglycemia/basics	/definition/con-20021103>					:
	information (to who						
	3/10/16. Diagnoses are not limited to prijoint, chronic pain, r Foley catheter-a fleurethra and into the aftercare following j	dmitted to the facility on so for Resident # 3 included but esence of right artificial knee retention of urine (requiring a xible tube passed through the bladder to drain urine), coint replacement surgery and litus (high blood sugar).					

PRINTED: 06/21/2016

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			10	18 NO. 0938-	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVE COMPLETED	ΞΥ
		495420	B. WING			C 06/09/201	6
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	00/09/201	0
ALBEMA	ARLE HEALTH AND R	EHABILITATION CENTER		1540 FOUNDERS PLACE CHARLOTTESVILLE, V	A 22902		
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F 281	Continued From pa	ge 35	F 2	281			
	and 6/9/16. Resider Data Set (MDS- an Assessment Refere Resident #3 with no indicated by a BIMS Status) of 15. In ad Resident # 3 requiri Activities of Daily Litransferring, dressir ROM (Range of Mo impairment to the loa catheter was in us The physicians orde "Oxycodone tablet stablet by mouth ever pain." The start date The admission date at approximately 1:0 (Medication Administ through March 30, 2 for pain on each dathe day Resident #3 No clinical notes do asked for pain mediadmission. No clinical Resident #3 receives 3/10/16. On a clinical regards to Gabaper and at 14:17 (2:17 got here and med hipharmacy yet". Accondministration Reconderical parts of the second media the control of the second media the second media the control of the second media the second med	riew was conducted on 6/8/16 at # 3's Admission Minimum assessment protocol) with an ence Date of 3/17/16 coded o cognitive impairment as 6 (Brief Interview Mental Idition, the MDS coded ng extensive assistance for ving care (Ambulating, ng, and bathing). Documented tion) on the MDS indicated ower extremity and confirmed se upon admission. Bers for Resident #3 read, 6 MG (milligrams); Give 1 ary 4 hours as needed for e on this order was 3/10/16. For Resident # 3 was 3/10/16. For Resident # 3 was 3/10/16. For Resident # 3 was 3/10/16, was admitted to the facility. Cumented that Resident #3 deation on the day of eal notes documented that any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note dated 3/10/16 in out of any pain medication on all note of any pain medication on all note of any pain medication on out of any pain medication on all note of any pain medication					

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p.m.) and 2100 (9:00 p.m.). The Physician's Order for Gabapentin 300 MG read, "Give 300

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 36 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO 0938-0391

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		495420	B. WING	;		0	C 6/09/2016	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		154	REET ADDRESS, CITY, STATE, ZIP COD 0 FOUNDERS PLACE ARLOTTESVILLE, VA 22902		9.00,2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IQULD BE	IX5) COMPLETION OATE	
F 281	chronic pain" with our line a phone interview at 2:06 pm Resident pain on the day he was could not recall whe pain medication from the nursing staff. As facility staff did not lidelivered from the p. When asked which referring to he state no time frame given notes do not convey received pain medical admission to the factor of National part of the month of the state of the state of the state of the month of the state o	imes a day related to other reder and start date 3/10/16. If with Resident #3 on 6/8/16 at #3 explained that he was in was admitted to the facility. He en or who he had asked for m. He referred to all staff as according to Resident #3 the have the pain medication obharmacy when he asked. pain medication he was and, "Oxycodone". There was a by Resident #3. Nursing y that Resident #3 asked for or cation on 3/10/16, the day of cation on 3/10/16, the day of cation on 3/10/16, the day of cation on 3/10/16 at 12:20 p.m. the cursing) provided the Stat box infest and stated, "Oxycodone pox". In an interview with the last (Others #4) on 6/9/16 at [#3's] medications were 24, 2016 (Pharmacy Review cond to last or the last week of a #4 confirmed that Oxycodone arch 10, 2016 in the facility ly, Others #4 stated, "usually I dereconcile when and to whom the tions are given! don't see it on the state of the last week of the facility of reconcile when and to whom the state of the last week of the state of the last week of the state of the last week of the state of the		281				
		g the medication from the Stat r must be notified of a request						

FORM CMS-2567(02-99) Previous Versions Obsolete

for medication then a hard copy script must be sent to facility and to the pharmacy. Once the

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 37 of 56

JUL 0 1 2016 VDH/OLC

PRINTED: 06/21/2016

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AL DEM	DIE UENITU AND D	EHABILITATION CENTER		154	0 FOUNDERS PLACE		
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F 281	Continued From pa	ge 37	F:	281			
	pharmacy receives authorizing access pharmacy sends ar open the Stat Box. the previous order (and a new script multiple of the previous order (and a new script multiple of the previous order (and a new script multiple of the previous order of the pharmacist (Others First, the Request for substance Medicati Supply authorizing to Oxycodone 5 MG from 7:04 p.m. with a fax "URGENT". Second dated 3/10/16 at 8:0 Oxycodone 5 MG, note "MD (doctor) with the document entitle New Admission Melinitial admission order was filled and center on 3/10/16 at 7:04 p.m. the control box." Documentation sup was taken from the p.m. however, no decould support if Resmedication. No one DON) could verify of the previous order of the p.m. however, no decould support if Resmedication. No one DON) could verify of the previous order of the p.m. however, no decould support if Resmedication. No one DON) could verify of the previous order of the p.m. however, no decould support if Resmedication. No one DON) could verify of the previous order of the pr	the script the doctor is to the Stat Box so the access code to the facility to This new prescription negates (usually for a 30 pill supply) ust be written for the next day. Were presented by the affect of the controlled on from the Contingency the facility staff to remove from the stat box on 5/10/16 at time of 7:33 p.m. and labeled on the faxed physicians order of p.m. for Resident #3 for a levery 6 hours for pain with a faxent 1 out of stat box." Third, and, "Timeliness of Receiving dications" documented the ler was received by the left at 1:53 p.m. and the original received by the nursing the 10:52 p.m. with an additional one one of the faxent of t					

According to the Pharmacist during an interview on 6/9/16 at 9:30 a.m., "We [Pharmacist and

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

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		495420	B. WING _		06	C 5/ 09/20 16	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902	ODE	3/09/20 16	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 281	the medications are 6/9/16 at 10:00 a.m medication from the the facility but "It is [nursing staff] need medication". No documentation to was given to Reside presented nor was after admission on: The DON noted, "Tupon admission" for Assessment on 3/10 confirmed, "yes [paipain" and a numeric though 10, with 10 to other pain assessm staff on 3/10/16 for The Lippincott Manuedition on page 16 sedocumentation, "A concise state decisions, actions, a provided, including should be done at the because passage of accurate recollection reference on pages claims most common professional nurses departures from appassess the patient	to reconcile to know where the reconcile to know where the According to the DON on the nurse that pulled the estat box no longer works at my expectation that we to account for each to support that pain medication ent #3 on 3/10/16 was a pain assessment performed 3/10/16. There was a pain assessment resident #3. The pain 0/16 at 13:39 (1:39 p.m.) In present]; right knee, nerve that rating score of 6 [out of 1] the most severe pain]. No ents were performed by the Resident #3. Lual of Nursing Practice 10th estates concerning nursing deviation from the protocol ted in the patient's chart with ments of the nurse's and reasons for the care any apparent deviation. This me time the care is rendered of time may lead to a less than of the specific events." This 16 and 17 states, "Legal		31			

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measures, communicate information about the

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 39 of 56

JUL 0 1 2016
VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

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		100120			TARRESON OFFICE TO ASPE	1 00/0	9/2016
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ALBEMA	RLE HEALTH AND RI	EHABILITATION CENTER		CHA	RLOTTESVILLE, VA 22902		
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F 281	Continued From pa	ge 39	F:	281			
	•	acility policy or procedure,					i
i	document appropria	ate information in the medical medications as ordered" (1)					
! 	The facility adminis	tration was informed of the					
	findings during a bri						1
		am. The facility did not					
	present any further	information about the findings.					·
		M. Lippincott Manual of					
		Philadelphia: Wolters Kluwer illiams & Wilkins, 2014.					
	Complaint deficience 483.25 PROVIDE C HIGHEST WELL BI	ARE/SERVICES FOR	F	309			
		receive and the facility must					
	or maintain the high mental, and psycho	ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment			How the corrective action was accomplished for the resident affected.	/ill be	
	and plan of care.						
					Patient #3 no longer resides a Albemarle Health and	at	:
		NT is not met as evidenced			Rehabilitation Center.		
	by:	rview, clinical record review					
	and complaint investo assess and imple	stigation, the facility staff failed ement interventions for pain ne of 6 residents in the sample					;
	(Resident #3).	·					
		o follow physician orders, e interventions for pain for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event 1D: XD6111

Facility ID: VA0417

If continuation sheet Page 40 of 56

STATEMENT OF OSFICIENCIES AND PLAN OF CORRECTION (X1) PROVODER SUPPLIER A BULLONG A BULLONG A BULLONG B. WINS STREET ADORESS, CITY, STATE, ZIP CODE 1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902 CHARLOTTESVILLE, VA 22902 FREDIX PROVIDER FOR USE TENDED TO PREDIX PROVIDER SUPPLIER TAG SUMMARY STATEMENT OF OSFICIENCES PREDIX BEGINNERS TO PROVIDERS PLACE CHARLOTTESVILLE, VA 22902 FREGULATORY OR LSC IDENTIFYING INFORMATION) Facility staff failed to provide pain medication (Oxycodone 5 MG) as needed on 3/10/16 for Resident #3. No evidence was presented by facility staff failed to provide pain medication (Oxycodone 5 MG) as needed on 3/10/16 for Resident #3. No evidence was presented by facility staff failed to provide pain medication (Oxycodone 5 MG) as needed on 3/10/16, nor was there an assessment regarding Resident #3 spain, nor was there evidence of any other (non-pharmacological) interventions to assist Resident #3 with his pain on 3/10/16. Diagnoses for Resident #3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes mellitus (high blood sugar). A clinical record review was conducted on 6/8/16 and 6/8/16. Resident #3 s' Admission Minimum Data Set (MDS- an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental Status) of 15. In addition, the MDS coded Resident #3 requiring extensive assistance for Activities of Daily Living care (Ambulating,	DEPAR	IMENI OF HEALIH	AND HUWAN SERVICES		·	FORM APPROVED
AND PLAN OF CORRECTION A99420 B. WING C. O6/09/2018 NAME OF PROVICER OR SUPPLIER ALBEMARLE HEALTH AND REHABILITATION CENTER (XA) ID SUMMARY STATEMENT OF OFFICIENCIES PREFER (EACH OFFICIENCY MUST BE PRECEDED BY PULL PAGE) FERFIX (EACH OFFICIENCY MUST BE PRECEDED BY PULL PAGE) FERRIFIX (EACH OFFICIENCY MUST BE PRECEDED BY PULL PAGE) FEGULATORY OR LSC IOENTIFYING INFORMATION) Facility staff failed to provide pain medication (Oxycodone of MG) as needed on 3/10/16 for Resident #3. No evidence was presented by facility staff that Resident #3 received Oxycodone of MG on 3/10/16, nor was there an assessment regarding Resident #3's pain, nor was there evidence of any other (non-pharmacological) interventions to assist Resident #3 with his pain on 3/10/16. Diagnoses for Resident #3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes medilitus (high blood sugar). A clinical record review was conducted on 6/8/16 and 6/9/16. Resident #3 s' Admission Minimum Data Set (MDS- an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental Status) of 15. In addition, the MDS coded Resident #3 requiring extensive assistance for Activities of Daily Living care (Ambulating,	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER ALBEMARLE HEALTH AND REHABILITATION CENTER (X4] IO PREFIX (EACH GERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 40 Facility staff failed to provide pain medication (Oxycodone 5 MG on 3/10/16, nor was there an assessment regarding Resident #3's pain, nor was there evidence of any other (non-pharmacological) interventions to assist Resident #3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes melittus (high blood sugar). A clinical record review was conducted on 6/8/16 and 6/9/16. Resident #3's Admission Minimum Data Set (MDS- an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief interview Mental Status) of 15. In addition, the MDS coded Resident #3 requiring extensive assistance for Activities of Dally Living care (Ambulating,				1 .		COMPLETEO
ALBEMARLE HEALTH AND REHABILITATION CENTER SUMMARY STATE MENT OF OFFICIENCIES (EACH OSE) EMPREED (SAD HOSE) (EACH OSE) (ENCHENCY MINE THE PRECEDIO SEE FULL PREFIX (EACH OSE) (ENCHENCY MINE THE PRECEDIO SEE FULL PREFIX (EACH OSE)			495420	B. WING		\$
ALBEMARLE HEALTH AND REHABILITATION CENTER (X4) ID (SAL) ID (SAL) OF FIGURE (SAL) OF SAL OF	NAME OF	PROVICER OR SUPPLIER		<u> </u>	•	
FREFIX TAG (EACH OFFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Facility staff failed to provide pain medication (Oxycodone 5 MG) as needed on 3/10/16 for Resident #3. No evidence was presented by facility staff failed to provide pain medication (Oxycodone 5 MG) as needed on 3/10/16 for Resident #3. No evidence was presented by facility staff that Resident #3 received Oxycodone 5 MG on 3/10/16, nor was there an assessment regarding Resident #3's pain, nor was there evidence of any other (non-pharmacological) interventions to assist Resident #3 with his pain on 3/10/16. Diagnoses for Resident #3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes mellitus (high blood sugar). A clinical record review was conducted on 6/8/16 and 6/9/16. Resident #3's Admission Minimum Data Set (MDS- an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental Status) of 15. In addition, the MDS coded Resident #3 requiring extensive assistance for Activities of Daily Living care (Ambulating,	ALBEMA	ARLE HEALTH AND R	EHABILITATION CENTER			
Facility staff failed to provide pain medication (Oxycodone 5 MG) as needed on 3/10/16 for Resident #3. No evidence was presented by facility staff that Resident #3 received Oxycodone 5 MG on 3/10/16, nor was there an assessment regarding Resident #3's pain, nor was there evidence of any other (non-pharmacological) interventions to assist Resident #3 with his pain on 3/10/16. Diagnoses for Resident #3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the urethra and into the bladder to drain urine), aftercare following joint replacement surgery and type II diabetes mellitus (high blood sugar). A clinical record review was conducted on 6/8/16 and 6/9/16. Resident #3's Admission Minimum Data Set (MDS- an assessment protocol) with an Assessment Reference Date of 3/17/16 coded Resident #3 medicated by a BIMS (Brief Interview Mental Status) of 15. In addition, the MDS coded Resident #3 requiring extensive assistance for Activities of Daily Living care (Ambulating,	PREFIX	(EACH OEFICIENC)	MUST BE PRECEOEO BY FULL	PREFI	X (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF	HOULO BE COMPLETION
transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission. The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for	F 309	Facility staff failed to (Oxycodone 5 MG) Resident #3. No end facility staff that Re 5 MG on 3/10/16, in regarding Resident evidence of any oth interventions to asson 3/10/16. Resident # 3 was and 3/10/16. Diagnose are not limited to projoint, chronic pain, in Foley catheter-a fleurethra and into the aftercare following type II diabetes medicated by a BIMS Status) of 15. In acceptant #3 required Activities of Daily Later transferring, dressis ROM (Range of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicated by a side of Mc impairment to the Ida catheter was in undicat	to provide pain medication as needed on 3/10/16 for vidence was presented by sident #3 received Oxycodone for was there an assessment #3's pain, nor was there her (non-pharmacological) sist Resident #3 with his pain dmitted to the facility on so for Resident #3 included but resence of right artificial knee retention of urine (requiring a exible tube passed through the exibition of the facility of the exibition of the facility of the exibition of the MDS coded ing extensive assistance for iving care (Ambulating, ng, and bathing). Documented option) on the MDS indicated ower extremity and confirmed se upon admission.	F3	accomplished for the residents with the paraffected by the same Current patients will be ensure a pain assess been completed and if for pain management implemented. A pain and interventions will implemented for any identified without a parassessment or without management interventions.	ose otential to be e practice. e reviewed to ment has interventions have been assessment be patients ain ut pain

The admission date for Resident #3 was 3/10/16

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495420	B. WING	;		C 06/09/2016		
	PROVIDER OR SUPPLIER IRLE HEALTH AND RI	EHABILITATION CENTER		154	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOUNDERS PLACE ARLOTTESVILLE, VA 22902	1 00,00,2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION		
F 309	(Medication Administhrough March 30, 2 for pain on each da the day Resident #3 No clinical notes do asked for pain med admission. No clinical Resident #3 receives 3/10/16. On a clinic regards to Gabaper and at 14:17 (2:17 got here and med high pharmacy yet". Acc 300 MG for chronic 1700 (5:00 p.m.) and Physician's Order for "Give 300 MG by m to other chronic pai 3/10/16. According to the Ca and revised/cancele was at risk for pain have decreased conceived with three in relaxation technique activities", 2. "Medic "Position resident for documentation that Interventions were at 2:06 pm Residen pain on the day here	ge 41 20 pm. According to the MAR stration Record) for March 1 2016, Oxycodone was given y except for March 10, 2016, 8 was admitted to the facility. cumented that Resident #3 ication on the day of cal notes document that ed any pain medication on all note dated 3/10/16 in hith 300 MG for chronic pain o.m.) indicated "Resident just ave not arrived from ording to the MAR Gabapentin pain was given on 3/10/16 at ad 2100 (9:00 p.m.). The or Gabapentin 300 MG read, outh four times a day related in with order and start date here Plan created on 3/11/16 and on 3/30/16, Resident #3 The goal read, "Resident will implaints of pain through next interventions: 1. "Encourage es and provide diversion cate as ordered" and 3. For comfort. There was no any of these Care Planned used by staff on 3/10/16. With Resident #3 on 6/8/16 at #3 explained that he was in was admitted to the facility on out recall when or who he had	F	309	Measures in place to ensure practices will not occur. Staff Coordinator/designee wiservice charge nurses on poli and procedure for Pain Management to include follow physician orders, assessing, providing interventions for pair management for acute and che pain on admission &/or new puthat is not usual for the patient administration and effectivene pain medication, notification or physician when pain is not relimedication is not available, and unusual findings and specific interventions based on individing patient needs. Staff Coordinator/designee wiservice charge nurses on proceeding of obtaining controlled medical from the Stat Box and docume administration afterwards in the clinical medical record to include appropriate information (to whom was given, when it was given why it was given).	ill in- icy ving and in hronic pain t, ess of f ieved, ny ual Ill in- cess ations enting ne ude nom it		

FORM CMS-2567(02-99) Previous Versions Obsolete

asked for pain medication from. He referred to all staff as the nursing staff. According to Resident

Event ID: XD6111

Facility IO: VA0417

If continuation sheet Page 42 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	1B NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		NSTRUCTION	((X3) DATE SURVEY COMPLETED
		49542 0	B. WING	·			C 06/09/2016
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		1540 F	T ADDRESS, CITY, STATE, ZIP CO OUNDERS PLACE LLOTTESVILLE, VA 22902		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E	
F 309	medication deliverer asked. When asked was referring to he was no time frame ontes do not convey received pain medicadmission to the factor of the contains on the Mars 5 MG is in the stat of Pharmacy Consultants as the month. Others was available on Mars was avail	lid not have the pain d from the pharmacy when he d which pain medication he stated, "Oxycodone". There given by the resident. Nursing that Resident #3 asked for or cation on 3/10/16, the day of	F	309	How the facility plan and ensure correction achieved and sustains. Unit Manager/designed 24 hour report and do of new admissions five week for four weeks to patients were assessed interventions were imply pain management and physician orders were Unit Manager will review manifest weekly for for ensure any removed of narcotic was documentaterwards in the clinic record to include appredisposition. Any deficit will result in re-educated disciplinary action as in the Director of Nursing will findings to the QA conquarterly for tracking as	on is ned. ee will re cuments e times o ensure ed and plements d that e followe ew Stat our week controlle nted cal medi ropriate sient pra- sion or indicated	eview ation a e e e e e e e e e e e e e e e e e e

FORM CMS-2567(02-99) Previous Versions Obsolete

Three documents were presented by the Pharmacist (Others #4) on 6/9/16 at 9:30 am.

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 43 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NC	0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
				,			С
		495420	B. WING	<u> </u>		06	5/09/2016
NAME OF	PRDVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
AI BEMA	RIFHEALTH AND R	EHABILITATION CENTER		1	0 FOUNDERS PLACE		
				CH,	ARLOTTESVILLE, VA 22902		
(X4) ID P R EFIX TAG	(EACH DEFICIENCY	(TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	substance Medicatic Supply authorizing to Oxycodone 5 MG from 7:04 p.m. with a fax "URGENT". Second dated 3/10/16 at 8:00 Oxycodone 5 MG, note "MD (doctor) wentities, "Timeliness Medications" documenter was received at 1:53 p.m. and the received by the nurs 10:52 p.m. with an a [Oxycodone] 5 MG; p.m.; Medication proposition of the p.m. however, no decould support if Resmedication. No one DON) could verify of medication (1 Oxycofrom the stat box has a coording to the Phon 6/9/16 at 9:30 a. know where the medication works at the facility	for Removal of controlled ion from the Contingency the facility staff to remove rom the stat box on 5/10/16 at a time of 7:33 p.m. and labeled d, the faxed physicians order 07 p.m. for Resident #3 for 1 every 6 hours for pain with a vants 1 out of stat box." Third is of Receiving New Admission by the pharmacy on 3/10/16 eroriginal order was filled and sing center on 3/10/16 at additional note, "Oxy #1 tablet on 3/10/16 at 7:04 ocured from the control box." Stat Box on 3/10/16 at 7:04 ocumentation nor interviews sident #3 actually received this erocument for where the codone 5 MG tablet) taken		309	DEFICIENCY)		
	medication was give	s found to support that pain en to Resident #3 on 3/10/16 essment performed after					

FORM CMS-2567(02-99) Previous Versions Obsolete

admission on 3/10/16. The DON stated, "There was a pain assessment upon admission for

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 44 of 56

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<u>,</u>			OMB NO	0. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		405420	B. WING				C	
		495420	B. WING		EET ADDRESS OFF STATE 7/2 OOD		5/09/2016	
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY. STATE. ZIP COD D FOUNDERS PLACE	=		
ALBEMA	RLE HEALTH AND R	EHABILITATION CENTER			ARLOTTESVILLE, VA 22902			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION OATE	
F 309	3/10/16 at 13:39 (1: present); right kneer rating score of 6 [or most severe pain]. The Lippincott Manedition on page 16 documentation, "A compared should be documented decisions, actions, ac	admission pain assessment on 39 p.m.) confirmed, "yes [pain not pain" and a numerical at of 1 though 10, with 10 the states concerning nursing deviation from the protocol ated in the patient's chart with ments of the nurse's and reasons for the care any apparent deviation. This he time the care is rendered of time may lead to a less than on of the specific events." This is 16 and 17 states, "Legal only made against include the following propriate care: failure to properly or in a timely fashion, lers, follow appropriate nursing nicate information about the actility policy or procedure, ate information in the medical medications as ordered" (1) tration was informed of the	F	309				
	Nursing Practice. F	M. Lippincott Manual of Philadelphia: Wolters Kluwer /illiams & Wilkins, 2014.						

Complaint deficiency.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,			OMB NO. 0938-0391		
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO		
		495420	B. WING			C 06/09/2016		
NAME OF F	PROVIOER OR SUPPLIER			STI	REET AOORESS, CITY, STATE, ZIP COOR			
ALBEMA	RLE HEALTH AND R	EHABILITATION CENTER			0 FOUNDERS PLACE IARLOTTESVILLE, VA 22902			
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES ' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE APF OEFICIENCY)	OULO BE COMPLETION		
F 315	Continued From pa	ge 45	F:	315	F315 Dai	te 7/18/2016		
	RESTORE BLADD		F	315	How the corrective action accomplished for the resi affected.	will be		
Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless resident's clinical condition demonstrates the		cility must ensure that a the facility without an is not catheterized unless the condition demonstrates that			Patient #3 no longer reside Albemarle Health and Rehabilitation Center.	des at		
	catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.				How corrective action waccomplished for those residents with the poter affected by the same pr	ntial to be		
	by: Based on resident facility documentati review, and in the c investigation, the fa 1 of 6 residents (Re	interview, staff interview, on review, clinical record ourse of a complaint cility staff failed to ensure that esident #3) who was ler received appropriate			Current patients will be residentify patients with a For Catheter and to ensure the receiving catheter care as care planned and document the eTAR (electronic Treadministration Record). Measures in place to empractices will not occur	oley ney are s ordered, ented in atment		
	Resident #3 did not receive Foley Catheter Care from 3/10/16 through 3/25/16 as catheter care was not ordered, care planned, or documented in the clinical record (nursing notes and TAR-Treatment Administration Record). The findings included: Resident # 3 was admitted to the facility on 3/10/16. Diagnoses for Resident # 3 included but are not limited to presence of right artificial knee joint, chronic pain, retention of urine (requiring a Foley catheter-a flexible tube passed through the				Staff Development Coordinator/designee will charge nurses on providir appropriate services to provide to the control order for catheter care and ensure the catheter is call and documented in the clarecord.	l in-service ng atients clude an nd to re planned		

urethra and into the bladder to drain urine),

_		AND HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			<u>O</u> (\)	<u>/IB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COM	E SURVEY PLETED
		495420	B. WING)		0 6/ 0	_ 09/2016
NAME OF F	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
		errand travious of Nation		154	10 FOUNDERS PLACE		
ALBEMA	RLE HEALTH AND K	EHABILITATION CENTER		CH	ARLOTTESVILLE, VA 22902		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(XS) COMPLETION DATE
E 045	0	- 40		045			
F 315	Continued From pa	_	₽.	315	How the facility plans to me	nitor	
		joint replacement surgery and			and ensure correction is		
	type II diabetes me	llitus (high blood sugar).			achieved and sustained.		
	A clinical record rev	view was conducted on 6/8/16					
		nt # 3's Admission Minimum			Unit Manager/designee will re		
		sment protocol) with an			24 hour report, new orders ar		
		ence Date of 3/17/16 coded			documentation of new admiss		
		cognitive impairment as			five times a week for four week	eks to	
		6 (Brief Interview Mental			ensure patients with a Foley Catheter have an order for ca	thotor	
		ddition, the MDS coded ing extensive assistance for			care, a care plan for the cath		•
		iving care (Ambulating,			and documentation in the clir		
		ng, and bathing). Documented			record that catheter care is be		
	ROM (Range of Mo	otion) on the MDS indicated			provided as ordered. Any de		
	impairment to the lo	ower extremity and confirmed			practice will result in re-educa		
	a catheter was in u	se upon admission.			or disciplinary action as indica		
		nysicians orders summary			Director of Nursing will report	+	
		h 6/30/16 presented by the			findings to the QA committee		
i		orders were written on 3/10/16			quarterly for tracking and tree	ndina.	
	regarding Foley Ca	theter Care for resident #3.			quarterly for tractioning of the tract	,3.	
	The first order docu	ımented, "Change Foley					
		30 days and PRN [as needed]"					
		of 3/10/16 but with a status of					
	"discontinued" with	no start or end date.					
	shift" also with an o	documented, "Foley care q order date of 3/10/16 and with tinued" with no start or end					
	(specify size and bate of 3/10/16 but						
	"discontinued" with	no start or end date.					

According to the TAR (Treatment Administration Record) dated March 1 through March 30, 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0301

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION		ATE SURVEY MPLETED
		49542 0	B. WING			04	C 6/09/2016
	PROVIOER OR SUPPLIER	EHABILITATION CENTER		1540	EET ADORESS, CITY, STATE, ZIP COOE) FOUNDERS PLACE ARLOTTESVILLE, VA 22902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	JX5J COMPLETION DATE
F 315	days and PRN, Foleballoon), Foley care had signed to indicaperformed for Residual 3/10/16 until the Foley catheter care clinical nursing or CAssistant) notes. On through 3/30/16 for documented that, "I Catheter for a diagronly listed two interdiscomfort on urina	-	F3	15			
((((Care mentioned as obtain the goal, "Re	re Plan was Foley Catheter part of the interventions to esident will be/remain free of trauma through review date (*)".					
	interview on 6/8/16 "We know cath [Ca sign off on the TAR Record]". She also discontinued on the	DN (Administration #2) in an at 9:30 a.m. it was stated, theter] care was done, we just [Treatment Administration stated that catheter care was physician's orders- "There nd that no one had signed off as completed.					
		CNA #1 (worked with 7 a.m. to 3 p.m.) on 6/8/16 at					

12:03 p.m. she stated, "I performed Foley care each day with a shower or bed bath" and

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			C	OMB NO. 0938-0391
STATEMENT DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILO		(X3) DATE SURVEY COMPLETED		
		495420	B. WING	;		C 06/09/2016
NAME OF PROVIDER OR SUPPLIER ALBEMARLE HEALTH AND REHABILITATION CENTER				154	REET ADDRESS, CITY, STATE, ZIP CODE 10 FOUNDERS PLACE	
				СН	ARLOTTESVILLE, VA 22902	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE COMPLETION
	nowhere to docume documented on the assignment sheets. DON was asked to worked with Reside Foley Catheter Care No other CNAs wer Catheter Care was According to Reside "Catheter care [cathever performed, stit was very full and osure how often [the According to the Converse-Administration approximately 9:15 entitled, "Ancillary Nerovided the policy Foley Catheter Care policy with an effect staff may 1. Utilize I Long-Term Care Astextbook as directed activities will be reflicare. The text head Indwelling Catheter Edition, 2015, page Administrative staff documented, "Provided the genital sufficient. Follow the sufficient. Follow the sufficient. Follow the sufficient. Follow the	daily showers" and "There is ent Foley care but showers are ADL [Activities of Daily Living] "On 6/8/16 at 12:05 p.m. the locate any other CNAs that int #3 that could confirm that a was performed each shift. e able to verify that Foley performed each shift. ent # 3 on 6/8/16 at 2:06 p.m. neter cleaned/sanitized] was taff would empty the bag when checked it [the bag] but not bag was checked]." orporate RN (Registered on #3) on 6/9/16 at a.m., the facility policy Jursing Care and Services" and procedure protocol for a. According to the facility Mosby's Textbook for sistants or an approved d and 2. Specifics of care ected in the patient's plan of ing "Caring for Persons with s" taken from Mosby's, 7th	F	315		

FORM CMS-2567(02-99) Previous Versions Obsolete

confirm that Foley Catheter Care was performed for Resident #3 or that Foley Catheter Care was

Event ID: XD6111

Facility ID: VA0417

If continuation sheet Page 49 of 56

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		495420	B. WING			C	C 6/09/2016
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		1540 FOUN	DRESS, CITY, STATE, ZIP (IDERS PLACE ITESVILLE, VA 22902	CODE	
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F 315	findings during a brapproximately 11:00	e Plan. tration was informed of the	F3	15			
F 431 SS=D	Complaint deficience 483.60(b), (d), (e) L LABEL/STORE DR	-	F 4	31			
	a licensed pharmac of records of receip controlled drugs in accurate reconcilial records are in orde	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable antion; and determines that drug r and that an account of all maintained and periodically		Ho ac aff Pa Alt	131 ow the corrective accomplished for the fected. attent #3 no longer rebemarle Health and enabilitation Center.	e resident(s) resides at	9
	labeled in accordar professional princip appropriate access	als used in the facility must be nee with currently accepted les, and include the ory and cautionary e expiration date when		ac res	ow corrective action complished for the sidents with the posterior by the same	ose otential to be	ì
	facility must store a locked compartmen	State and Federal laws, the II drugs and biologicals in ints under proper temperature to only authorized personnel to keys.		rev me to e nai	re facility stat box may removed for any controlled controlled consure reconciliation reprised and to ensure cumentation in the commentation in the commentation in the consureres.	rolled pain since 6/9/2016 on of the e appropriate	
	permanently affixed controlled drugs list	ovide separately locked, I compartments for storage of ted in Schedule II of the ug Abuse Prevention and		me giv wa	edical record (to who ren, when it was giv is given). Pharmac tified of any discrep	om it was en and why it y will be	t

Control Act of 1976 and other drugs subject to

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			49542 0	B. WING	·		C 0 6 /0 9/2 016
_	NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	
ALBEMARLE HEALTH AND REHABILITATION CENTER						0 FOUNDERS PLACE ARLOTTESVILLE, VA 22902	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
	F 431	Continued From pa	ge 50	F4	431		
		abuse, except wher package drug distril	n the facility uses single unit oution systems in which the inimal and a missing dose can			Measures in place to ensur practices will not occur. Staff Development Coordinator/designee will in-scharge nurses on process of	
		by: Based on resident facility documentation review, and in the convestigation, the fail narcotic (Oxycodon	interview, staff interview, on review, clinical record ourse of a complaint cility staff failed to reconcile a e 5 Milligrams) taken from the			reconciling a narcotic taken fithe stat box and documenting administration afterwards in to clinical medical record to include appropriate information (to what was given, when it was given why it was given).	he ude hom it
		The Pharmacist (Ot narcotic (Oxycodon (Medication Adminis Nursing Record) tal 3/10/16 at 7:04 p.m	hers #4) failed to reconcile a e 5 MG tablet) with the MAR stration Record and Clinical en form the stat box on . to relieve Resident #3's pain.			How the facility plans to n and ensure correction is achieved and sustained. Unit Manager will review Stamanifest weekly for four we ensure any removed control narcotic was reconciled and	at Box eks to lled
		3/10/16. Diagnoses are not limited to prijoint, chronic pain, refoley catheter-a flex urethra and into the aftercare following juype II diabetes mel A clinical record revand 6/9/16. Resider	dmitted to the facility on for Resident # 3 included but esence of right artificial knee etention of urine (requiring a kible tube passed through the bladder to drain urine), point replacement surgery and litus (high blood sugar). iew was conducted on 6/8/16 at # 3's Admission Minimum sment protocol) with an			documented afterwards in the clinical medical record to incomprehensive disposition. Any deficient practice will result education or disciplinary act indicated. Director of Nursing will report findings to the QA committed quarterly for tracking and trees.	he clude y in re- tion as rt e

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Assessment Reference Date of 3/17/16 coded Resident #3 with no cognitive impairment as indicated by a BIMS (Brief Interview Mental

Event IO: XD6 t11

Facility ID: VA0417

If continuation sheet Page 51 of 56

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

F 431 Continued From page 51 Status) of 15. In addition, the MDS coded Resident # 3 requiring extensive assistance for Activities of Dally Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission. The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." The start date on this order was 3/10/16. The admission date for Resident # 3 was 3/10/16 at approximately 1:00 pm. According to the MAR (Medication Administration Record) for March 1 through March 30, 2016, Oxycodone was given for pain on each day except for March 10, 2016, the day Resident #2 was admitted to the facility. No clinical notes documented that Resident #3 asked for pain medication on the day of admission. No clinical notes documented that Resident #3 received any pain medication on 3/10/16. In a phone interview with Resident #3 on 6/8/16 at 2:06 pm it was explained that he was in pain on	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	<u>MB NO</u>	. 0938-0391
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY WIST DE PRECEDIA OF CORRECTION (PS) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY WIST DE PRECEDED BY FULL PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY) F 431 Continued From page 51 Status) of 15. In addition, the MDS coded Resident #3 requiring extensive assistance for Activities of Daily Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission. The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." The start date on this order was 3/10/16. The admission date for Resident #3 was 3/10/16 at approximately 1:00 pm. According to the MAR ((Medication Administration Record) for March 1 through March 30, 2016, Oxycodone was given for pain on each day except for March 10, 2016, the day Resident #2 was admitted to the facility. No clinical notes documented that Resident #3 asked for pain medication on the day of admission. No clinical notes documented that Resident #3 received any pain medication on 3/10/16. In a phone interview with Resident #3 on 6/8/16 at 2:06 pm it was explained that he was in pain on	NAME OF I	PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, Z	ZIP CODE	<u> </u>	
CHARLOTESVILLE, WA 22902 (K4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH ODRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 431 Continued From page 51 Status) of 15. In addition, the MDS coded Resident #3 requiring extensive assistance for Activities of Daily Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission. The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." The start date on this order was 3/10/16. The admission date for Resident #3 was 3/10/16 at approximately 1:00 pm. According to the MAR (Medication Administration Record) for March 1 through March 30, 2016, Oxycodone was given for pain on each day except for March 10, 2016, the day Resident #2 was admitted to the facility. No clinical notes documented that Resident #3 asked for pain medication on the day of admission. No clinical notes documented that Resident #3 received any pain medication on 3/10/16. In a phone interview with Resident #3 on 6/8/16 at 2:06 pm it was explained that he was in pain on	AL DELGA	ADLE HEALTH AND D	CHADILITATION CENTED		1540	FOUNDERS PLACE			
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FA31 Continued From page 51 Status) of 15. In addition, the MDS coded Resident #3 requiring extensive assistance for Activities of Daily Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission. The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." The start date on this order was 3/10/16. The admission date for Resident # 3 was 3/10/16 at approximately 1:00 pm. According to the MAR (Medication Administration Record) for March 1 through March 30, 2016, Oxycodone was given for pain on each day except for March 10, 2016, the day Resident #2 was admitted to the facility. No clinical notes documented that Resident #3 asked for pain medication on the day of admission. No clinical notes documented that Resident #3 received any pain medication on 3/10/16. In a phone interview with Resident #3 on 6/8/16 at 2:06 pm it was explained that he was in pain on	ALDENIA	AKLE FICALIFI AND K	EHABILITATION CENTER		CHA	RLOTTESVILLE, VA 22	902		
Status) of 15. In addition, the MDS coded Resident # 3 requiring extensive assistance for Activities of Daily Living care (Ambulating, transferring, dressing, and bathing). Documented ROM (Range of Motion) on the MDS indicated impairment to the lower extremity and confirmed a catheter was in use upon admission. The physicians orders for Resident #3 read, "Oxycodone tablet 5 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." The start date on this order was 3/10/16. The admission date for Resident # 3 was 3/10/16 at approximately 1:00 pm. According to the MAR (Medication Administration Record) for March 1 through March 30, 2016, Oxycodone was given for pain on each day except for March 10, 2016, the day Resident #2 was admitted to the facility. No clinical notes documented that Resident #3 asked for pain medication on the day of admission. No clinical notes documented that Resident #3 received any pain medication on 3/10/16. In a phone interview with Resident #3 on 6/8/16 at 2:06 pm it was explained that he was in pain on	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
not recall when or who he had asked for pain medication from. He referred to all staff as the nursing staff. According to Resident #3 the facility staff did not have the pain medication delivered from the pharmacy when he asked. When asked which pain medication he was referring to he stated, "Oxycodone". There was no time frame given by the resident. Nursing notes do not convey that Resident #3 asked for or	F 431	Status) of 15. In adr. Resident # 3 require Activities of Daily Litransferring, dressin ROM (Range of Moimpairment to the loa catheter was in use The physicians orde "Oxycodone tablet stablet by mouth ever pain." The start date The admission date at approximately 1:0 (Medication Administration of March 30, 2 for pain on each dathe day Resident #2 No clinical notes do asked for pain med admission. No clinical Resident #3 receives 3/10/16. In a phone interview at 2:06 pm it was exthe day he was adminot recall when or with moiting staff. According facility staff did not delivered from the pwhen asked which referring to he state no time frame giver	dition, the MDS coded ing extensive assistance for iving care (Ambulating, ng, and bathing). Documented otion) on the MDS indicated ower extremity and confirmed se upon admission. ers for Resident #3 read, 5 MG (milligrams); Give 1 ery 4 hours as needed for e on this order was 3/10/16. The for Resident #3 was 3/10/16 on pm. According to the MAR stration Record) for March 1 2016, Oxycodone was given by except for March 10, 2016, 2 was admitted to the facility. Documented that Resident #3 ication on the day of call notes documented that ed any pain medication on the the facility. He could who he had asked for pain the referred to all staff as the reding to Resident #3 the have the pain medication on the was ed, "Oxycodone". There was no by the resident. Nursing		¥31				

admission to the facility.

received pain medication on 3/10/16, the day of

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC	TIPLE CONST	RUCTION			TE SURVEY MPLETED
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				1540 FOU	INDERS PLACE			
ALBEMA	KRLE HEAL H AND K	EHABILITATION CENTER	ļ	CHARLO	TTESVILLE, VA	22902		
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F 431	Continued From pa	nge 52	F٠	431				
	DON (Director of N contains on the Ma 5 MG is in the stat I Pharmacy Consulta 8:45 am, Resident reviewed on March is always on the set the month). Others was available on M Stat Box. Additional look at the MAR and the stat box medication the MAR for March 11, 2016." The Pharmacist (of process of obtaining Box. First the doctofor medication there sent to facility and the pharmacy receives authorizing access pharmacy sends are open the Stat Box. Three documents we pharmacist (Others	on 6/8/16 at 12:20 p.m. the ursing) provided the Stat box nifest and stated, "Oxycodone box". In an interview with the ant (Others#4) on 6/9/16 at #3's medications were 24, 2016 (Pharmacy Review cond to last or the last week of #4 confirmed that Oxycodone arch 10, 2016 in the facility Ily, Others #4 stated, "usually I'd reconcile when and to whom ations are given! don't see it rch 10, 2016! only see it on thers #4) explained the g the medication from the Stater must be notified of a request to the Stat Box so the access code to the facility to This new prescription negates (usually for a 30 pill supply) ust be written for the next day.						

substance Medication from the Contingency Supply authorizing the facility staff to remove Oxycodone 5 MG from the stat box on 5/10/16 at 7:04 p.m. with a fax time of 7:33 p.m. and labeled "URGENT". Second, the faxed physicians order dated 3/10/16 at 8:07 p.m. for Resident #3 for Oxycodone 5 MG, 1 every 6 hours for pain with a

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2016 FORM APPROVED OMB NO. 0938-0391

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mu A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495420	B. WING			C 06/09/2016
	PROVIDER OR SUPPLIER ARLE HEALTH AND R	EHABILITATION CENTER		154	REET ADDRESS, CITY, STATE, ZIP CODE 10 FOUNDERS PLACE IARLOTTESVILLE, VA 22902	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE COMPLETION
F 431	note "MD (doctor) ventitled, "Timeliness Medications" documorder was received at 1:53 p.m. and the received by the nur. 10:52 p.m. with an a [Oxycodone] 5 MG p.m.; Medication procumentation sup was taken from the p.m. however, no doculd support if Resmedication. No one or DON) could verification (Oxycodone) at the process of 6 pulled the medication was a pain assess admission on 3/10/was a pain assess admission on 3/10/was a pain assess Resident #3. The passes of 6 [out of 1 severe pain]. No other contents of the process of 6 and 1 severe pain]. No other contents of the process of 6 and 1 severe pain]. No other contents of the process of 6 and 1 severe pain]. No other contents of the process of 6 and 1 severe pain].	ge 53 vants 1 out of stat box." Third of Receiving New Admission hented the initial admission by the pharmacy on 3/10/16 original order was filled and sing center on 3/10/16 at additional note, "Oxy #1 tablet on 3/10/16 at 7:04 ocured from the control box." ported that Oxycodone 5 MG Stat Box on 3/10/16 at 7:04 ocumentation nor interviews sident #3 actually received this (nursing staff, pharmacists, y or account for where the done 5 MG) had gone. Itarmacist during an interview m., we have to reconcile to adications are. According to at 10:00 a.m. the nurse that on from the stat box no longer but "It is my expectation that it for each medication" No found to support that pain en to resident #3 on 3/10/16 essment performed after 16. The DON stated, "There nent upon admission" for ain assessment on 3/10/16 at onfirmed, "yes [pain present]; ain" and a numerical rating through 10, with 10 the most ner pain assessments were aff on 3/10/16 for Resident #3.		431		

The Lippincott Manual of Nursing Practice 10th edition on page 16 states concerning nursing

		AND HOMAIN SERVICES			FOR	MAPPROV E D
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	O. 0938-0391
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/\				CHARLOTTESVILLE, VA 229	02	
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F 431	Continued From pa	nge 54	F 43	1 1		
, ,,,		deviation from the protocol	('1 \) i		
	should be documer	nted in the patient's chart with				
		ements of the nurse's and reasons for the care				
		any apparent deviation. This				
		he time the care is rendered				
		of time may lead to a less than on of the specific events." This				
		s 16 and 17 states, "Legal				
	claims most commo					
		s include the following propriate care: failure to				
	assess the patient	properly or in a timely fashion,				
		lers, follow appropriate nursing				
		nicate information about the acility policy or procedure,				
	document appropria	ate information in the medical				
	record, administer r	medications as ordered" (1)				
		edication Supplies Policy last				
		Bentitled, "Long-Term Care				
		Pharmacy Products and Pharmacy" documented the				
		macy to identify which				
		tion Supplies have been				
		ility should notify Pharmacy of "Facility should return opened				
		for review and reconciliation				
	of any discrepancie	es."				
	The facility adminis	tration was informed of the				
	findings during a br	iefing on 6/9/16 at			^=\\	
		0 am. The facility did not information about the findings.		KE	CEIVED	
	p. ocom any larator			11 11	0 1 2016	
1				JUL	. y i /IIIN	

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

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	MB NO. 0938-0391
	(X3) DATE SURVEY COMPLETED
495420 B. WING	C 06/09/2016
NAME OF PROVIDER OR SUPPLIER ALBEMARLE HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH OEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	BE COMPLÉTION
F 431 Continued From page 55 F 431	
Complaint deficiency.	
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